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Showdown on the Yangtze

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COVER: HMS *Amethyst* enters Hong Kong on 3 August 1949 following her harrowing escape down the Yangtze River. Many of the British frigate's crewmen, wounded in a little known episode during the Chinese Civil War, owed their lives to a U.S. Navy physician. Story on page 27. Image of *Amethyst* from a painting by John Worsley in the collection of K. Stewart Hett. Cover art by Linda Roop, Visual Information Specialist, Medical Graphic Arts Department, NMSC, Bethesda, MD.

We Want Your Opinion

Letters to the Editor are welcome. Please let us know what you think about *Navy Medicine*. Please send letters to: Janice Marie Hores, Managing Editor, Bureau of Medicine and Surgery (M09B7C), 2300 E Street, NW, Washington, DC, 20372-5300 or Janice.Hores@med.navy.mil.

Online issue of *Navy Medicine* can be found at the GPO website <http://permanent.access.gpo.gov/>

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Donnie Edwards (left), linebacker for the Kansas City Chiefs, and Drew Brees, quarterback for the New Orleans Saints, pose with HM3 Corey Adam during the players' visit to EMFK (Expeditionary Medical Facility Kuwait) 12 April 2007. Photos by HN Brandi Ford, USN



Actor Gary Sinise tours EMFK with CDR Kimberly Shipley during Sinise's visit 19 May 2007. EMFK staff gather for a group photo with Sinise, who currently stars in CSI: New York and is known as “LT Dan” in “Forrest Gump.” Sinise toured camps in Kuwait and Iraq with the USO. Photo by MC1(SW) V.S. Cindy Gill, MTF/EMFK Public Affairs



Are You Prepared for Deployment?

If you are part of Navy medicine, a new accession, being deployed, or just wanting to expand your operational knowledge, then the Expeditionary Medicine Web Based Training course (EMWBT) should be on your short list to complete. The EMWBT was developed from the Expeditionary Medicine Training Working Group. The group identified a need for basic operational familiarization for all Navy medicine personnel. NAVMED POLICY 07-016 requires all newly accessed Navy Medical Department personnel (officer, enlisted, active, and reserve) complete the EMWBT within their first 2 years.

EMWBT is comprised of five courses that are available on Navy Knowledge Online (NKO). They include tactical combat casualty care, combat related skills, non-combat related skills, patient movement, and shipboard operations. These five courses can be taken independently by accessing NKO and going to Navy e-learning.

How to get started?

1. First open NKO at the following link: <https://wwwa.nko.navy.mil>
2. Once NKO is open go to the learning tab. The link looks like this:
Navy e-Learning
3. Then click the following tab:
E-Learning auto tab or click the picture image stating Access Navy e-Learning
4. On your left hand side click on:
Browse Categories
5. Click on:
Department of the Navy Training
6. Then Click:
Navy Medical Education and Training
7. Then click:
Expeditionary Medicine
8. You should get a screen that lists the courses below. Go ahead and enroll!

CATALOG CODE

Expeditionary Medicine - Combat Related Field Skills	NMEMCRFS061
Expeditionary Medicine - Non-Combat Related Field Skills	NMEMNCRFS061
Expeditionary Medicine - Patient Movement	NMEMPATMOV061
Expeditionary Medicine - Shipboard Operations	NMEMSHIPOP061
Expeditionary Medicine - Tactical Combat Casualty Care	NMEMTCCC061

For information concerning content, please contact the Expeditionary Medicine department at NAVMED MPT&E at 301-319-4918. Information provided by CAPT Martie Slaughter, PAO, NAVMED, MPT&E

Read any good books lately?

Navy Medicine is looking for book reviews. If you've read a good book dealing with military (Navy) medicine and would like to write a review, the guidelines are:

- Book reviews should be 600 words or less.
- Introductory paragraph must contain this information: Book name by author. Publisher, city, state. Year published. Number of pages.
- Reviewer ID: sample:
CAPT XYZ is Head of Internal Medicine at Naval Medical Center San Diego.
Send submission for consideration to Janice Marie Hores, Managing Editor, at: janice.hores@med.navy.mil
I look forward to hearing from you.

Issued Body Armor Is Best Available for Combat

The Marine Corps wants its Marines and sailors to know that the body armor it issues is the best available for combat despite recent inquiries concerning replacement gear. The Marine Corps issued armor has met government test standards, and in many cases, the standards exceed civilian testing, said MAJ Bradford W. Tippet, infantry advocate for Headquarters Marine Corps in a recent interview with reporter LCPL David Rodgers.

Recent media attention has painted commercial body armor with the notion of being an alternative to the gear already being issued, but such armor is not required to meet government test standards and, therefore, does not necessarily provide the same level of protection to the Marine, said Tippet. "Don't believe everything you see on TV or the Internet," said Tippet. "We have a great group of Marines and civilians whose only job is to ensure that we have the right requirements for our armor that truly meet the standards we require."

The Corps' department for plans, policy, and operation published in April the policy on wear and purchase of personal protective equipment. It states that Marines and sailors may not replace issued armor with commercial protective equipment; however, commanders may authorize the use of commercial armor if it doesn't interfere with the functionality of the issued gear.

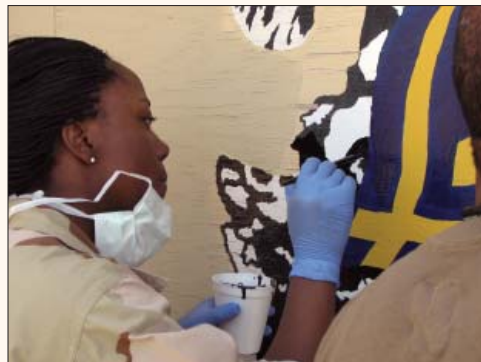
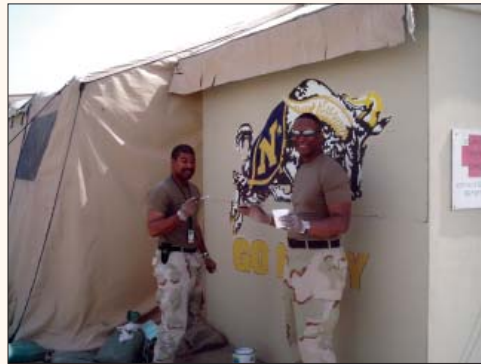


The Modular Tactical Vest (MTV) comes with several components that the wearer must configure and maintain. The MTV, which doubles as body armor and load-bearing vest, features many improvements over the Outer Tactical Vest currently fielded to most Marine units. A quick-release mechanism allows Marines to get out of the vest hastily in emergency situations and allows for immediate medical access. The vest provides more protection from shrapnel in the lower back and kidney area and protects the side torso area from bullets thanks to the integration of side armor plate carriers. The integrated cummerbund provides the improved load carriage and weight distribution. Photo by SGT Ethan E. Rocke, USMC

However, more armor could be a hindrance on, for instance, a foot patrol with a full battle load and temperatures reaching up to 115 degrees in some operational zones.

Moreover, commanders are also not authorized to use unit funds to purchase commercial items that do not meet government test standards. Marines can buy their own equipment, but they will not be reimbursed.

—News Release, Marine Corps News, Headquarters Marine Corps, Washington, DC.



The Navy goat symbol was originally painted by an earlier detachment, but had become weathered. Top: PS1 Brian Ross and RP1 Rodney Johnson, and bottom: HN Brandi Ford repaint detail of the Navy goat on the side of the Administration building. Middle: HM3 Andrew Jenkins traces the frame of the Marine Corps emblem on the opposite side of the admin tent. Photos courtesy of MC1(SW) V.S. Cindy Gill, MTF/EMFK Public Affairs, Kuwait

Freedom Is Not Free Providing Flights for Wounded

Freedom Is Not Free (FINF) is partnering with Executive Wings on a program called “Jets for Vets” in order to ease the burden of the cost of transportation for wounded military personnel and their families. The program enables volunteers to make would-be empty travel seats available on private jets to those wounded while serving. “Non-conforming” relatives such as fiancés, best friends, grandparents, and significant others who do not qualify for Department of Defense travel benefits may also take advantage of the program.

Jets for Vets is a charitable initiative of the Executive Wings alliance, made up of the world’s top pre-owned business jet dealers and brokers. Its members recognize the sacrifice of those who serve and recognize the additional strain placed on those who require medical treatments or physical therapy as a result of injuries suffered while serving. They also recognize the tremendous benefit that can come as a result of having loved ones present during the recovery process. However, realizing that substantial financial burdens are often a side-effect, Jets for Vets donors seek to alleviate at least one obstacle for wounded troops and their families.

Through the FINF website, those in need of transportation may submit a request detailing their travel needs. FINF will work with Jets for Vets to seek a solution. Launched in March 2007, the initiative has already garnered several volunteers who have generously donated their private planes for the program and looks forward to building an extensive database that will allow FINF and Jets for Vets to assist as many of our military personnel as possible.

The initiative has also received a positive reception from the start, as shown by GEN Colin Powell, who thanked Jets for Vets founder Tony Smith, saying “I am sure this will be appreciated by many of our troops who have served us so nobly.”

Please visit the FINF website at: www.FreedomIsNotFree.com for more information or to request a flight through the Jets for Vets program.✍

—Story by Liz Wegman, USMC, Public Affairs.

NMSC Ensures Reservists Practice Medicine

The Executive Committee for Medical and Dental Staff (ECOMS/DS) held a monthly meeting recently to review the credentials files of Navy Reserve practitioners. This committee, consisting of both reserve and active duty medical staff officers, serves one of Navy medicine’s most important functions—recommending a



medical practitioner for independent service in one of hundreds of military healthcare clinics and hospitals worldwide.

NMSC’s Centralized Credentialing and Privileging Department (CCPD), the host of the ECOMS/DS, has a unique mission of supporting the Navy Surgeon General/Chief, Bureau of Medicine and Surgery in the management and maintenance of Individual Credential Files (ICFs) for the Navy Reserve healthcare providers.

The credential files contain the documents that Reserve Navy medicine medical providers must have to provide healthcare. CCPD maintains the ICFs for Licensed Independent Practitioners, including physicians, dentists, nurse practitioners, and other allied healthcare givers. CCPD also maintains the Individual Professional Files (IPFs) for Navy Reserve clinical support staff such as professional nurses and dental hygienists.

CCPD uses this system to grant privileges to more than 2,000 healthcare providers serving across the Navy Reserve, ensuring providers have the proper education, training, licenses, certifications, and current competency and skills within their chosen clinical specialty.

“Having the centralized credentials files here at NMSC is like dealing a deck of cards,” said Sandra Banning, CCPD’s department head. “We hold all the cards (credentials files), and we deal them from here via electronic credentials transfer briefs. We know where the surgeons are located, we know where all the family physicians are located, and we know where the clinical support staff are located.”

Banning said Navy medicine is better served by keeping every provider’s credential file in one location thereby minimizing delay in the credentialing and privileging process.

During the June ECOM/DS meeting, members spent the day discussing and reviewing the credential files before making their recommendations to NMSC’s Chief of Staff, William Lorenzen, the sole privileging authority for all Navy Reserve component providers.

The ECOM/DS was formed in 1993 after then Navy Surgeon General VADM Donald F. Hagen decided to centralize all the reserve medical providers who need to be privileged or critical support staff in one location. This critical mission belonged to the Naval Healthcare Support Office located in building H2005, which later transitioned to become Navy Medicine Support Command in November 2005.

“Operation Desert Shield and Desert Storm in the early 1990s let us know that at the time we couldn’t effectively identify our Reserve component medical assets. For example, when physicians needed a billet they were often placed into any physician billet regardless of their specialty.” Banning said. “When Desert Shield/Desert Storm occurred, we needed to know where our assets were and how they were distributed. CCPD helps BUMED reach that goal.”

At the conclusion of the monthly ECOMs meeting, NMSC’s Chief of Staff has a number of applications and endorsement pages requiring his endorsement. After signing, the medical and dental providers are notified their privileges have been approved for the next 2 years, at which time, the entire cycle begins again.✍

—Story by MC1(SW/AW) Jeffrey McDowell, Navy Medicine Support Command PAO, Jacksonville, FL.

DOD Announces Program to Recognize Frequent Deployment

The Department of Defense (DOD) recently announced a program to recognize service members who deploy or mobilize beyond the established rotation policy goals. The goals for the Active and Guard/Reserve units are 1 year deployed to 2 years at home station (1:2) and 1 year mobilized to 5 years demobilized (1:5) respectively.

Administrative absence will be granted to service members when these goals are not met and can be used at their convenience. This is provided to enhance the service member's quality of life and will be done on the following basis:

- 1 day for each month a service member is deployed over 12 of 36 consecutive months of active duty or over 12 months of a 72-month period mobilized for the guard/reserves.
- 2 days will be granted when thresholds of more than 18 of 36 consecutive months for active duty or 18 of 72 months for the guard/reserve are exceeded.
- 4 days will be provided when thresholds of more than 24 of 36 consecutive months for active duty or 24 of 72 months for the guard/reserve are exceeded.

Administrative absence is authorized by the commander. It is separate and distinct from normal leave accrued by a service member.✍

—Department of Defense Press Release 18 April 2007.

President's Commission on Care for America's Returning Wounded Warriors Launches a New Website

The President's Commission on Care for America's Returning Wounded Warriors has launched a public website for servicemen and women to share their stories about the continuity of care they received from the time they were hurt on the battlefield through the transition to civilian life or back to active duty service. The "share your story" section is on the official commission website <http://www.pccww.gov>—which will provide the public with information on commission activities.

Commission co-chairs, former Senator Bob Dole and former Health and Human Services Secretary Donna E. Shalala, urged our nation's wounded warriors to log on and share their experiences with the commission. "We are committed to listening to those on the frontlines of care—both the providers and the brave men and women who have been injured and require care," Senator Dole said. "We want to find out what is and what isn't working as we set about developing recommendations for the president."

"This Commission has a big mission with a short time frame," said Secretary Shalala. "We will not be able to get to every location we would like to visit. That's why this website

is so important. We need our wounded warriors to bring us, in their own voices and in their own words, their healthcare experiences."

Servicemen and women who have been wounded in Iraq or Afghanistan who want to share their stories with the commission can do so online using two methods: They can either go to <http://www.pccww.gov> and click on the "Share Your Story" link, and send it into the commission; or, they can email their story directly to the commission at PCCWW.Feedback@wso.whs.mil.

All information that is shared via this website will become part of the public record of the commission. The nine-member President's Commission on Care for America's Returning Wounded Warriors was tasked by President Bush to "conduct a comprehensive review of the care America is providing our wounded servicemen and women returning from the battlefield."✍

For more information contact Nicholas J. Graham, 703-588-0407, nicholas.graham@wso.whs.mil

Department of Defense Announces Partnership with the Florida Agency for Health Care Administration

The Department of Defense (DOD), together with Florida's Agency for Health Care Administration, has partnered to pursue an interoperable network for sharing electronic medical information. This marks the first time that DOD has formed a network with a non-federal entity to share electronic medical records.

This pilot collaboration between DOD and Florida is a model initiative to create a mechanism to share and exchange personal health information and data. Through this relationship, state healthcare providers who treat current and former military personnel and their families will have an opportunity to electronically access and exchange personal health information about their patients. When fully implemented, this initiative will improve providers' ability to access and share information that may be used to treat uniformed and retired personnel at DOD and non-military locations.

"Today the Military Health System and the state of Florida begin an unprecedented partnership to exchange healthcare information that will enhance quality and efficiency for our mutual beneficiaries," said Dr. Stephen Jones, principal deputy assistant secretary of defense for health affairs. "We hope to use the successes of this collaboration as a model to form sharing agreements with other states and healthcare entities in the future. It is an important step forward for healthcare IT."

In 2004, President George W. Bush called for all Americans to have a privacy-protected electronic medical record by 2014. In August 2006, he expanded this initiative by calling on federal agencies providing healthcare to share electronically health information with each other and also with their

private sector partners to enhance the quality and continuity of care for their beneficiaries.

This new partnership between the State of Florida and DOD, will be executed through the Tampa Bay Regional Health Information Organization (RHIO), a state- and privately-funded entity.

“On behalf of all Floridians, I am honored the Department of Defense has selected our state as the inaugural site for this groundbreaking exchange of electronic health information,” said Dr. Andrew Agwunobi, secretary of the Florida Agency for Health Care Administration. “This partnership will not only enhance the quality of healthcare services provided to Florida’s active and retired military personnel and their families, it will strengthen Florida’s efforts to bring this vital health information technology to Floridians state-wide.”

The location of this pilot project will be the Tampa Bay area, with the Tampa Bay RHIO taking the lead in developing the interface with AHLTA, the Military Health System’s (MHS) electronic health record system.

The MHS has approximately 700,000 beneficiaries who are residents or part-time residents of Florida, in addition to a large number of beneficiaries who visit the state and may find themselves in need of healthcare during their visit.

Because of the comprehensiveness of the clinical data AHLTA collects, and because of the high number of active duty and retired military and their dependents living in or visiting the state of Florida, DOD has the ability to provide vital information to Florida’s physicians to assist them with the care they provide service members and their families, while at the same time stimulating the further development of Florida’s health information technology network and its ability to share electronic health information. ✍

—Department of Defense Press Release 4 April 2007.

DOD Begins Electronic Transfer of Digital Radiographs

The Department of Defense announced it has begun to transmit electronically the digital images of medical scans, such as MRI and CAT scans, for critically injured soldiers who are transferred from the Walter Reed Army Medical Center and the National Naval Medical Center to the Veterans Affairs Poly-trauma Center in Tampa, FL.

Previously, images were copied from the local Picture Archive and Communication System (PACS) at Walter Reed or Bethesda to a compact disc. The compact disc was then hand-carried by the patient or a family member to the VA facility.

Automation of this process reduces the risk of data loss, eliminates the burden of responsibility for delivery of imaging data from the patient or family and allows providers at the VA to better prepare for the arrival of the patient at the Poly-trauma Center.

Dr. Stephen Jones, the principal deputy assistant secretary of defense for health affairs, applauded the rapid develop-

ment and deployment of the image transfer process, “Once again, we have shown the tremendous progress that can be made when DOD and the VA work together, united by a single purpose and guided by our determination to improve the healthcare for our returning service members,” he said.

The success of early trials and the speedy implementation of this program can be credited to a joint DOD/VA team of imaging experts. Working together, we can now share images including computed radiology, digital radiography, computerized tomography, magnetic resonance, and ultrasound.

The majority of critically wounded patients are transferred from Walter Reed, Bethesda, and Brooke Army Medical Center to the four VA Poly-trauma centers located in Tampa, FL, Richmond, VA, Minneapolis, MN, and Palo Alto, CA.

Now that digital image transfer has been successfully implemented between Walter Reed, Bethesda, and the Poly-trauma center in Tampa, the plan is to add Brooke Army Medical Center to the sites sending images and make this service available to the remaining three VA Poly-trauma locations as soon as possible. ✍

—Department of Defense Press Release 17 April 2007.

DOD Receives Independent Review Group Report

The Independent Review Group (IRG) established by Secretary of Defense Robert Gates provided DOD with its assessment of rehabilitative care and the administrative processes at the Walter Reed Army Medical Center (WRAMC) and the National Naval Medical Center (NNMC) on 16 April.

The department intends to quickly evaluate the recommendations in order to establish an action plan for change. In anticipation of the IRG findings and recommendations, the department recently requested an adjustment to the fiscal year 2007 emergency supplemental request to provide \$50 million to create a medical support fund. This will allow DOD to promptly implement these and other recommendations that may be forthcoming.

The department is currently surveying wounded warriors and their families to assess their needs. With the Department of Veterans Affairs, DOD has begun the process of redesigning the disability evaluation and separation systems and is implementing initiatives to transfer medical records between the two agencies electronically.

The results of all the reviews being conducted by the Department of Veterans Affairs Task Force on returning global war on terror heroes and the recommendations of the President’s Commission on Care for America’s Returning Wounded Warriors will likewise provide invaluable advice to chart the way forward for the care of our service members. ✍

—Department of Defense Press Release 19 April 2007.

Navy Medicine Begins Lean Six Sigma Training

The first wave of Navy medicine Lean Six Sigma (LSS) green belt training for NMSC and Navy Medicine East commands was held here 23-27 April. The 21 graduates will serve as team members, responsible for measuring, analyzing, and improving processes at their command, said Felix Nazareno of NMSC, a lead black belt for the Navy medicine LSS program support office here.

Lean Six Sigma, or LSS, is a process evaluation and improvement method being implemented across Navy medicine and the Navy operational/line community. Navy Medicine Support Command is the LSS program manager for Navy medicine. The customer satisfaction-focused LSS program combines two approaches to process evaluation and improvement, said CAPT Judy A. Logeman, director, Process Management and Integration at the Bureau of Medicine and Surgery in Washington.

Lean is an analytical method that identifies wasted effort in an existing business process and focuses on streamlining for efficiency. Six Sigma is an evaluation method that focuses on quality and aligns business processes with customer requirements and needs.

The new green belts spent the week studying and practicing LSS language, concepts, and techniques, said Scott A. Olivolo, NMSC Credentials and Privileging director and a graduate of the green belt training.

The class was taught by instructors from Booz Allen Hamilton, a management consulting firm that works with private business and government.

"Gaining the perspective of private sector consultants who actually managed LSS projects for large corporations truly gave me a perspective on how significant LSS can be to Navy medicine," Olivolo said.

Prior to volunteering to be LSS green belt trained, Olivolo was a team member on a black belt project studying the Navy contracted healthcare worker credentialing process, the process used to verify a medical provider's qualifications and licensing. He said his future green belt project will likely focus on the privileging vice credentialing process, where a healthcare worker is given authorization by a Navy clinic or hospital to see patients in its facility.


Besides the amount of training and expertise, Olivolo said the differences between green and black belts include the amount of time spent working LSS projects. "Green belts typically work on LSS projects on a part-time basis, managing only one or two projects, while the expectation for black belts is full-time dedication, managing several projects," Olivolo said.

Green belt training was given simultaneously in San Diego. Felipe G. Velasco Jr., a LSS master black belt from the NMSC Program management office, said green belt training



Front row (seated) l to r: Michael Washington, Margaret Reese, Laurie Hovermale, and CDR Kathryn Summers. Second row (standing) l to r: Scott Olivolo, LT Diego Esguerra, CDR Corazon Rogers, CDR Trisha Ofstad, LTJG Joseph Newman, HMC Adria Lauderdale, and HMC Paul Horn. Third row (rear) l to r: LTJG Michael Knoell, HMC Stacey Sanders, HMCS Sean Christopher, LTJG Kirt Nilsson, LTJG Byron Jordan, HM1 Ronnie Mashburn, LT Carlos Fairley, CDR Regina O'Nan, CDR Ronnell Leftwich, and Steven Turner. Photo by MC1 Jeff McDowell, USN

will continue to be offered throughout Navy medicine. Future training sites will also include Bethesda, MD, and Portsmouth, VA. All total, 200 Navy medicine green belts will be trained in eight classes through the end of fiscal year 2007, Nazareno said. More information on LSS or future training is available from Mr. Gregory Boatright at 904-542-7200, ext. 8283. The DSN prefix is 942. Boatright is a LSS master black belt at NMSC.

Logeman said the LSS program taught at Jacksonville is proven and has the potential to optimize business and clinical processes throughout Navy medicine. She said Navy medicine is currently bringing the process on board as illustrated by the ongoing green belt training. The Navy medicine goal is to institutionalize the LSS process and ensure continued alignment with SECNAV, OPNAV, and Military Health System LSS initiatives. 

—Story by Larry Coffey, NMSC, Public Affairs.

California first lady Maria Shriver met with combat wounded service members and their families about their experiences in Iraq at Naval Medical Center San Diego's Comprehensive Combat Casualty Care Center. Photo by MC3 Alexander Ameen, USN



New Dental “C” School Opens in San Diego

The Naval School of Health Science (NSHS) San Diego opened the Expanded Function Dental Assistant School at Naval Station San Diego, or “EFDA,” during a ribbon cutting ceremony 24 April.

The 18-week EFDA program provides students with 10 weeks of didactic lectures and clinical lab studies, and 8 weeks of hands-on clinical rotations. “It is a team approach,” said CAPT James Strother, EFDA department head. “It works because you have one doctor and five technicians treating three patients at the same time. We work smarter, increase procedures, and maintain the quality of care for our patients. It is a win-win situation.”

For example, technicians will be taught practice management--the process of treating multiple patients at one time by having the EFDA place tooth restorations or make temporary restorations after the doctor has prepared the teeth.

The official party attending the ceremony included senior leadership throughout Navy medicine including CAPT Robert Hutto, Navy Medicine West chief of staff; CAPT Robert Quinones, commanding officer of Navy Medicine Manpower, Personnel, Training & Education, the school’s parent command; CAPT Robin McKenzie, commanding officer, Naval School of Health Sciences; CAPT Debra Ryken, Naval School of Health Sciences executive officer; LCDR Robert Slaughter, Naval Medical Center & Naval School of Health Sciences chaplain; and MCPO Philip Tiotuico, Naval School of Health Sciences command master chief.

“It was wonderful to see the number of dental and medical officers who attended the ceremony,” said CDR Sam Westock, a prosthodontist and instructor in the new program and the master of ceremonies. “We were honored that the commanding officer, CAPT Dixon Smith, and CMC Benitez of Naval Station, San Diego, were present to celebrate this memorable day.”

“The Expanded Functions Dental Assistant Program is very near and dear to my heart, I have been working on the concept for many years, and the school is specifically devoted toward teaching expanded functions dental assistants to provide quality treatment,” said Hutto. “Today’s dental technicians want to do more, like their counterparts in the civilian practice.”

The state of California has two programs in expanded functions, and now the Navy has one that will provide its graduates with a Navy Enlisted Code, or “NEC,” which will allow the Navy graduates to practice in their field of expertise, Hutto explained.

That desire to do more was evident when the 25 student billets were filled by volunteers in 1 week despite the 2 years it took to complete the building renovations.

“My overall goals are to have better access to care and preventive measures because expanded functions is one huge part of the nervous system,” said Hutto. “We have to have dental assistants in the clinic who understand and know how to utilize expanded functions.”

The first EFDA students and the instructors alike are excited about the opportunities the new program will provide.

“It’s an honor to be able to go to this school, and I am excited to continue my education in the dental technician field,” said HM3 Mario Portillo, a fleet sailor attending the first class. “I love being in this field of expertise, and to stay in it you pretty much have to go to the Expanded Functions Dental Assistant School if you want to excel.”

“I think this class is going to be great,” said HM1(FMF) Dennis Lawrence, leading petty officer and an EFDA instructor. “Our staff has been working really hard everyday since we all checked in. I’m excited to be the first LPO of this class and to get this program off the ground.”

Closing remarks were made by Westock, who directly addressed the new EFDA students.

“I came into the Navy as an enlisted dental technician,” she said, “and before me, CAPT Ryken the executive officer, also a dental technician, and before her our newly selected admiral, CAPT [Richard] Vinci, dental technician. Someone once told me that you do not have to be the strongest or the fastest, but with desire you can do great things.”

—Story by CAPT Martie Slaughter, PAO, NAVMED, MPT&E.




CAPT Robin McKenzie, CO of NSHS San Diego, is pictured “cutting ribbon” to officially open the Expanded Functions Dental Assisting School. Assisting is CAPT Dixon Smith, CO Naval Base, San Diego and CAPT Robert Hutto, Navy Medicine West chief-of-staff. North Island Media photo

Navy Nurse Grad Program Ranked Near Top Nationally

The Navy Nurse Corps Anesthesia Program (NNCAP) headquartered at the Navy Medicine Manpower, Training and Education Command (NAVMED MPT&E) in Jacksonville was recently ranked third nationally from among 106 graduate school programs on the list of America's Best Graduate Schools-2008 as reported by *U.S. News and World Report* magazine. "This ranking is a direct reflection of the professionalism, skill, innovation, and hard work put forth by the NNCAP's impressive faculty members and also through our associations with excellent partners in education to include Georgetown University and the Uniformed Services University and their faculty members," said CAPT Ronald Olson, NNCAP director.

The program is based on a competitive selection process that evaluates both nurse and officer proficiencies. The program is an intense 30-month, two-phase program open to active duty nurses with at least 3 years of naval service. The Navy pays the full tuition, and the students continue to receive their regular pay while attending school. In addition, the candidates incur a 4-year service obligation following successful completion of the training program.

The program is designed to provide graduate-level education that enables the student to understand the scientific principles underlying anesthesia, critically analyze anesthesia literature, evaluate problems in anesthesia, provide independent anesthesia care, and conduct research to further the profession of nurse anesthesia. Graduates of this program are licensed independent practitioners educated to provide quality anesthesia care in diverse settings throughout the world. "Our program uses a human simulator lab unlike many of the civilian programs so that we are able to become experienced on all populations from pediatrics to geriatric," said LT Jason Pinfold, who just finished his first year of the program. "The program is very focused on evidence-based research and text books to ensure cutting-edge application and knowledge. We also receive up-to-date training on operational readiness from instructors who have just returned from combat, and we learn what it is like to be in combat."

"The faculty should be very proud of this monumental accomplishment," CAPT Roberto Quinones Jr., NAVMED MPT&E commanding officer, said of the school's recognition. "The faculty members are truly exceptional, and their commitment to success is certainly worthy of this national recognition." NAVMED MPT&E is accredited by the Commission of the Council on Occupational Education. More information on becoming a Navy Nurse is available at www.navy.com. 

—Story by HM2 Julie Urban and MC1(SW/AW) Jeff McDowell, Navy Medicine Support Command, Jacksonville, Public Affairs.



Naval Hospital Beaufort Nurses gather for a picture following a nurses' blessing ceremony during National Nurses' week. Photo submitted by Patricia Binns, Naval Hospital Beaufort Public Affairs

Keeping the Fit in Fitness Enhancement Program

Naval Hospital Bremerton Physical Therapy Department is finalizing procedures to engage in a trial program of injury prevention among Fitness Enhancement Program (FEP) service members.

The premise is based on the strong support coming from LCDR Julie Landecker, Physical Therapy department head, who is trying to mitigate the potential of injury to those active duty sailors on the FEP program. Citing information from several sources, Landecker attests that growing detail points to increased risk for common injuries brought on by overuse and overtraining. These injuries can include a multitude of muscle aches and pains, knee and hamstring injuries, shin splints, Achilles tendonitis, plantar fasciitis, ankle strains, and lower back pain.

"We need to do what is best for our Navy, but especially ensure we're also doing what is best overall for our sailors," Landecker said. "Take one of our submarine crews for example. Everyone is a vital member. Losing just one to an injury suffered, or to a condition worsened, could potentially have a rippling effect on overall readiness. We feel that we can help avoid losing our valuable shipmates."

"Our physical therapists are very effective in treating various musculoskeletal injuries resulting from overuse," Landecker continued. "We are also trained in identifying FEP participants at potential risk for a given injury, and of course for injury prevention."

But Landecker's idea is to try and get the word out before any injuries occur. According to her, most FEP members are not set up to avoid injury. Command fitness leaders (CFL) will receive several hour's training on an annual basis for nutrition, exercise, and administration concerns, but there is




Naval Hospital Bremerton staff members engage in a group warm-up session prior to their command physical readiness training.
Photo by HM2 Marika Steenblock

rarely any basic injury prevention included in the curriculum. In addition, the volunteers who have also traditionally assisted CFLs in the routine monitoring needs of FEP have always been chosen and accepted due to their own physical fitness and not necessarily because of their physiotherapy know-how. Since FEP is not optional and is mandated by the Chief of Naval Operations, keeping participants actively engaged and not lingering on the sideline nursing an injury is important, and CFLs and their assistants need at least rudimentary knowledge to make that happen.

"We'd like to do an outreach program for training purposes to all CFL and FEP personnel in our area," stated Landecker. "We will go out of our way to provide guidance to CFL and FEP leaders to prevent injury and help our sailors. We think that having a question and answer session, going over some basic understanding about the body's muscular-skeleton movement, capability and positioning, and even first-aid, can help to lessen the threat of any sailor getting hurt. The bottom line is to not have anyone suffer a set-back. We want all to show improvement, and hopefully also have some fun in the process."

Landecker points out that documented evidence shows that some of the risk factors associated with FEP injuries include a prior history of low back pain, and a sedentary lifestyle coupled with poor cardiovascular endurance. Her physical therapists can provide advice on core-training, gradual involvement from inactive to active and increased stamina, "which are all achievable goals," she said. "Any injury can potentially result in decreased or delayed participation in physical fitness training, and that in turn defeats the whole purpose of the fitness enhancement program. The bottom line is that we want all of our sailors to pass their physical readiness test, and in order for that to happen, they can't be injured, or keep re-injuring themselves."

Executing mission readiness is a primary undertaking for all commands. NHB's physical therapy is gearing up to help make certain that FEP is fit and able to do just that. 

—Story by Douglas H. Stutz, Naval Hospital Bremerton, Public Affairs.

NMCP Debuts Helical Tomotherapy in Hampton Roads

Naval Medical Center Portsmouth (NMCP) has become the only military hospital and the only hospital in Hampton Roads to use a new radiation treatment for cancer called helical tomotherapy. "It's similar to a catscan machine with a cover, and spins 360 degrees around a person," said LCDR Steven Miller, a radiation oncologist at NMCP. "It allows the most accurate treatment of tumors with fewer side effects compared to traditional radiation treatment."

Miller explained that helical tomotherapy allows a catscan every day using 3D imaging, unlike other treatments. This ensures the radiation is aimed precisely at a tumor and minimizes damage to surrounding tissue. "It 'scalops out' healthy tissue from radiation exposure, which makes it ideal for tumors near the eye, the brain, or other areas where an accurate aim is essential," said Miller.

When NMCP needed new radiation equipment, Miller was a proponent of helical tomotherapy. He had seen it in use at other institutions. Construction to accommodate the unit began last fall, and patients have been treated since January. The cutting-edge equipment is being used extensively. "Our first patient, a retired Navy chief, had a brain tumor, and he is now doing very well," said Miller. "Another patient, a woman with lung cancer, previously received traditional radiation treatment. She says the new treatment is better." Shirley Bender is that patient. She has Stage 3A lung cancer and gushed about her helical tomotherapy treatment. "This is faster, quieter, and more accurate. This is 10,000 times better than the old one. It doesn't make you scared."

Edward Binkowski, a retired Navy legalman, is being treated for prostate cancer. "I love it and the people who are doing it. They're professional; they make you feel comfortable. I'm not nervous."

More than a dozen computers run the tomotherapy unit, which, even with a military discount cost about \$3.2 million. While NMCP was the first military hospital to acquire helical tomotherapy, the National Naval Medical Center in Bethesda, MD, is planning to install a unit.

University of Virginia Hospital in Charlottesville, Rockingham Memorial Hospital in Harrisonburg, and Inova Fairfax Hospital are the only other places where helical tomotherapy is offered in Virginia. Approximately 130 units are in operation in the U.S.

Additional information about the treatment may be found at www.tomotherapy.com. 

—Story by Deborah R. Kallgren, NMCP Public Affairs.



LCDR Steven Miller stands beside the new Helical Tomotherapy machine at Naval Medical Center Portsmouth. Photo by Deborah Kallgren

NHB MSC Lends Hand for Habitat for Humanity

Naval Hospital Bremerton's Medical Service Corps did not let a little winter weather get in their way of community service. Their charitable work brought more than hope on a wet weekend. They helped to strengthen and fortify New Hope, a new community of 18 new affordable homes under construction on New Hope Circle in West Bremerton.

The groundbreaking took place in mid-December, and actual construction began in January 2007. With the foundations poured, the next task up has been the framing, which was handled during a Blitz Build Week, culminating in a large turnout of volunteers helping out, including a group from Naval Hospital Bremerton's Medical Service Corps.

"Our organization got together and decided not too long ago that we wanted to do a worthwhile project outside of our own to give back to our community," said LCDR Kim Zuzelski, Master of Science, RD, CDE, CSSD, and MSC. "I've been involved in Habitat for Humanity before and knew that our group could certainly support such a worthwhile cause."

"A project like this is basically a gigantic coordination effort," said Tom Tinsley, site supervisor, who has been doing such volunteer work on behalf of Kitsap County Habitat for Humanity since 1995. "This is the 12th house I've helped to construct."

According to Tinsley, getting the best effort means organizing the tools and material and the individual skill levels of the volunteers to achieve maximum results.

The Saturday group effort was for the final day of their "blitz". The blitz concept is an overall concentrated and dedicated effort to come out and build as much of the structure as possible in 6 days. "We'd love to get the roof in also," said Tinsley. "This duplex we're working on is unique though. For one thing, we're putting in seismic anchors, and that's the first time we've done that. We've probably also had the worse weather ever in doing a blitz, because it's poured this past week."

"Despite the rain, it's really a lot of fun," Zuzelski said. "There's such a feeling of accomplishment to know that we're helping to build a home for someone who doesn't have one."

"What we're doing as volunteers in this project is not a handout, but a hand up," explained LCDR John Reitz, NHB Pastoral Care and MSC volunteer. "It's an important distinction and a perfect frame of reference that we're told at the beginning. By saying that we're involved in a hand up project and not just giving a handout helps to humanize this event. It gives ownership and also empowers those who benefit as well as us to make those necessary steps."



"For the want of a nail." CDR Derik Clay applies a little leverage in helping with construction of a new house to become a home for a deserving family in the Habitat for Humanity program. Photo by Douglas H. Stutz, Naval Hospital Bremerton Public Affairs

According to the official Kitsap County Habitat for Humanity website, the organization is a non-profit, ecumenical Christian housing ministry, which works in partnership with low- and very low-income families to lift them from substandard housing to a decent house in a decent neighborhood.

The concept is simple, yet very effective. By utilizing the ability, time, and effort of a wide variety of volunteers, and getting contributions and donations, Habitat for Humanity builds houses to make into homes, and enlists the future homeowners in the building process. The future homeowners are expected to pitch in with own labor, which is euphemistically called sweat equity, into helping construct their house and the houses of others.

One new proprietor at New Hope was a whirlwind of gracious assistance and bustling help. "We totally need a house," exclaimed Leah, one of the future homeowners. "I'm very excited to be a part of this project. It is such a great opportunity. I have two boys, age 14 and 6, and we will now have our own place."

According to compiled figures by Habitat for Humanity of Kitsap County, since 1992, a total of 32 homes in Kitsap County have been built, providing decent accommodation for 41 adults and 82 children. At New Hope Circle, along with the 18 new homes, there will also be a playground, gazebo, and community gardens. Those interested in volunteering can call 360-479-3853 for more information.✍

—Story by Douglas H. Stutz, Naval Hospital, Bremerton, Public Affairs.

Corpsman Strikes Gold, Lands a CASEVAC Billet

Most deployed Marines and sailors prefer a fast paced day where they are constantly busy and the deployment is quickly passing by. But, for HM3 James Phillips, a casualty evacuation hospital corpsman attached to Marine Medium Helicopter Squadron 161, a slow day is a good day. His job includes flying with the aircrew to the point-of-injury and picking up and treating patients. The aircraft then transports the patients to a level two or level three hospital facility, such as the level three hospital at Al Asad.

Phillips decided to heed the call to duty when a friend told him being a corpsman was the best job in the Navy. So, he postponed his college education to enlist in the Navy. Phillips has spent his career on the East Coast at Marine Corps Air Stations Beaufort, SC, and Cherry Point, NC. He deployed twice at each duty station, but always stayed on the ground at forward aerial refueling points, and going on patrols with explosive ordnance disposal teams and the infantry. He experienced many leadership styles and grew in maturity throughout his deployments. After an eventful enlistment with several deployments, Phillips was preparing to get out of the Navy when he finally struck gold, landing a casualty evacuation billet in Iraq. "I've been trying to get on the CASEVAC mission for 4 years," said Phillips. "This is my fifth deployment. I just took a 13-month extension to do this CASEVAC deployment."

To prepare for the current deployment, Phillips spent 4 weeks at Marine Corps Air Station New River, NC, attending the CASEVAC Course and Operational Emergency Medical Course. The CASEVAC Course focused on familiarizing corpsmen with getting patients into helicopters and flying, while the OEMC course taught them medical treatments. "OEMC was the best medical course I've ever been to," said Phillips. "It was cool to see how the treatments you learned worked on patients."

Corpsmen spring into action when greeted with the sound of the "Casevac Bell." Phillips' first thought is always the same. "I wonder what's going down. And then you get a big adrenaline pump and run out to the bird."

After the corpsmen reach the helicopter, they wait for the crew chief's signal to get on board, according to Phillips. "If we haven't gotten the nine-line, the pilots come over the inter-communications system and tell us what the nine-line is," said Phillips. "The nine-line includes the number of patients, where they are picking them up, whether they are military or civilian, type of injury, and where they need to be taken."

Upon arrival at the point-of-injury, one of the corpsmen runs out to retrieve the patient and the other stays as backup, according to Phillips. After the patients have been retrieved and are in the air, the corpsmen will each make an assessment of the patient and then tell the pilot where to go. They also



Corpsmen with Marine Medium Helicopter Squadron 161 rush to the aircraft after receiving the all clear signal from the crew chief. The corpsmen help prepare the CH-46E for flight when the "CASEVAC Bell" is sounded. Photo by LCPL Ryan R. Jackson, USMC, 2nd Marine Aircraft Wing (FWD).

provide whatever care is necessary to stabilize or help the patient. "We usually see a lot of gunshot and blast wounds," said Phillips. "The body armor prevents a lot of injuries. We are generally treating compound fractures and severe lacerations."

It is important for '161 to be on the scene as quickly as possible because giving immediate care to patients increases their chances for survival. "Getting the patients to medical facilities within the golden hour is very important," said the corpsman. "The quicker we get them there, the better chance we have to save their life or limb."

To ensure every crew is proficient, corpsmen fly in pairs. Sailors with more skill and experience are paired with sailors of lesser experience and familiarity. HN Roger Rose, with HMM-161, was the junior man paired with Phillips for the first month and a half of the deployment. "Phillips was like a big brother teaching me," said Rose. "We meshed well together. We picked up where the other lacked. We understood each other very well."

Phillips has always wanted to be a Marine aviator, and still intends to, but for now he is satisfied as a CASEVAC corpsman. "Flying the CASEVAC mission has been the highlight of my enlistment," said Phillips. "I look forward to it every time. I love the trauma aspect of being a medic and flying is a big rush. On days you fly, you really see the difference you make." ✍️

—Story by LCPL Ryan R. Jackson, 2nd Marine Aircraft Wing (FWD), Al Asad, Iraq.

EMFK Returns Brigade to the Fight

In the preceding 7 months, Expeditionary Medical Facility Kuwait (EMFK) has reached a milestone of returning to duty more than 1,700 soldiers and sailors to the global war on terrorism—a full brigade's worth who would have otherwise been evacuated out of theater.

A key to this success is EMFK's Theater Transient Hold Detachment (TTHD). This facility is the theater counterpart of a CONUS medical holding company. TTHD provides

administrative, transportation, and billeting support in addition to medical support. In October 2006, TTHD transferred from 1st Medical Brigade to become part of EMFK.

Soldiers and sailors going to Europe or CONUS have a much lower chance of returning to duty than those sent to EMFK. To overcome this, EMFK improved its efficiency and ability to handle more workload, then went out and asked units in Iraq, Afghanistan, and ships in the Arabian Gulf to send patients to Kuwait instead of Europe or CONUS. As a result, inbound medical evacuations doubled and surgical cases increased by 30 percent. "We keep soldiers and sailors in theater for their care and then get them back into the fight quickly. In a few short months, TTHD's statistics prove the effectiveness of this program," said CAPT C. Forrest Faison, EMFK's former commanding officer. "The average daily census increased from 30 patients to roughly 70 to 80 on any given day. Over 80 percent of those are from Iraq or Afghanistan."

TTHD receives approximately 190 patients per month, more than many major medical centers in CONUS. To minimize time away for medical care, EMFK put a full-time nurse in TTHD to care for recovering patients, ensure they followed treatment recommendations, track their progress, and manage their follow-up appointments. TTHD patients get priority for appointments and surgery. EMFK leadership gets daily briefings on patient access and length of stay. As a result, soldiers who used to wait an average of 2-3 days after arrival to be seen by a specialist are now seen the day they arrive and those needing surgery get it within 24 hours of arrival. A multi-disciplinary team was formed to regularly review each case to ensure continued progress and treatment appropriateness. In parallel, since much of the TTHD workload is surgical, EMFK explored ways to minimize recuperation time and improve efficiency in doing surgical procedures. They found that shifting to do surgery by scopes was more efficient and also allowed for smaller incisions, quicker healing, and quicker return to duty. On average, doing surgery by scope instead of open incision reduces recovery time by 1-2 weeks. As a result, EMFK implemented more surgery by scopes and fewer invasive procedures.

As a result of the improvements EMFK implemented, the average time a soldier is away from his unit for treatment decreased from 23 days to 6 days. Return to duty also increased from around 50 percent to 77 percent. The Assistant Secre-



HMC(FMF) Luisito Ayenta (left) and HM1 (SW/AW) Mario Suarez take a minute following a walk-through of a male berthing at the Theater Transient Holding Detachment. Photo by MC1(SW) Cindy Gill, Camp Arifjan, Kuwait, Public Affairs.

tary of the Army called the TTHD a "model for emulation" on a recent visit.

With the increase in surgeries, came a greater need for recuperative facilities. Physically, the Theater Transient Holding Detachment is comprised of three pre-construction buildings located at Camp Arifjan's Zone 6. Six corpsmen are assigned to the unit, three of whom live on site. A recent realignment of buildings centralized two buildings for male billeting and one female easily accessible to toilets/showers as well as the zone's dining facility. In parallel with care improvements, EMFK also undertook efforts to improve quality of life for patients. The facility was moved to be closer to the dining facility and the EMFK staff installed metal sidewalks so soldiers on crutches are not walking in the sand or on gravel.

Recent comfort improvements include new furniture, televisions, DVD players, Playstations, and computers for a mini "internet café."

"The internet café is a big plus for the patients since they are here away from both their families and their buddies in their unit. This allows them to stay in touch. It also means families are reassured about their loved ones and the care they are getting here" said Faison. TTHD staff maintains a designated patient bus to move patients according to their schedules and brings them literally to the door.

A service member can arrive at EMFK literally with the clothes on their back. TTHD staff will "greet them at the door" with necessary items for their stay.

TTHD maintain an assortment of new clothing for both male and female received via donations. If the patient needs an MRI, which is only conducted in local Kuwaiti medical facilities where civilian clothing is required, a clothes chit is issued so the member can buy clothing in the Exchange which they can keep.

Available personal care extends to personal hygiene items. TTHD has bins of shampoo, soap, shaving cream, and toothpaste. Residents are invited to take what they need.

"We try to keep a good supply so residents don't have to purchase these items while here," said LT Danette Piscopo, NC, TTHD site officer-in-charge. Other donations available for resident's comfort include fleece, cloth, and crochet afghans donated by stateside churches. Regardless of the type of medical assistance needed, the staff of EMFK and TTHD is committed to the finest care and comfort to the fighting forces who they help.

"TTHD is a true success story," said Faison. "We're here to do the best we can for those entrusted to our care and get soldiers and sailors healthy and back into the fight. EMFK is committed to doing all we can to make that happen as efficiently and effectively as we can while giving the best care we can to these heroes."✍

—Story by MC1(SW) Cindy Gill, Camp Arifjan, Kuwait.

Multilateral Medical Effort Eases Pain of Locals During Cobra Gold

Thai, U.S., Japanese, and Singaporean doctors shared resources to provide medical assistance to the residents of Prahuap at the Udomraj Pakdee School 11 May 2007, as part of exercise Cobra Gold 2007, a joint multilateral exercise focusing on enhancing security in the Southeast Region as well as providing humanitarian/civic assistance projects. This humanitarian assistance project is one of 11 being conducted during the exercise.

With medical check sheets in hand, each patient visited different stations for a full medical exam, including optometry, orthopedics, dental, physical therapy, and a basic health care assessment. Every ailment was treated, down to the smallest of aches and pains.

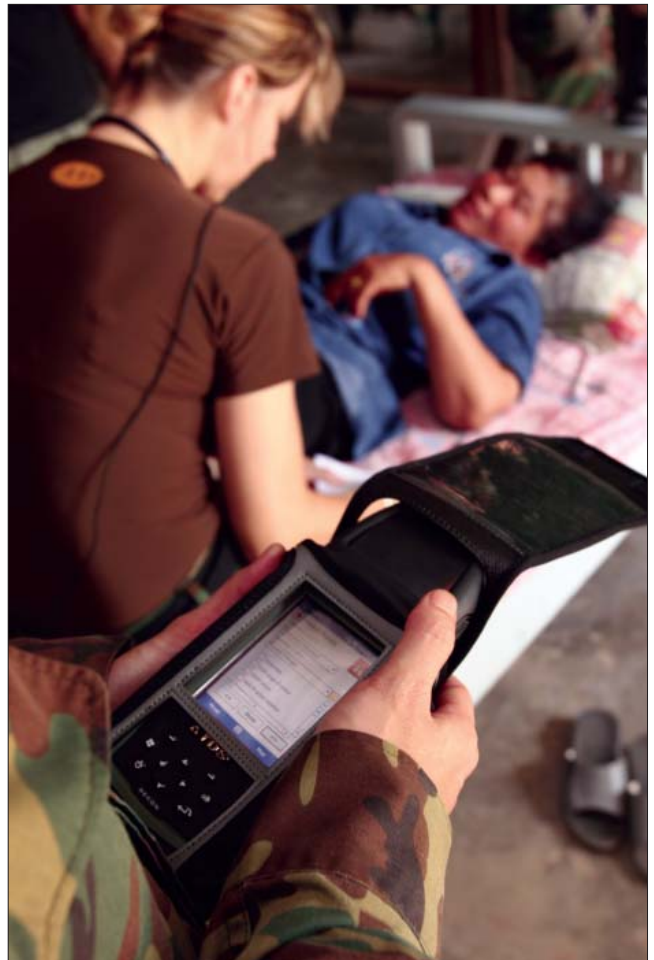
"It's amazing what some of these people endure," said HM1 Kevin Ashcraft, Operation Hospital Support Unit, Naval Hospital Camp Pendleton, CA. "One man had a 10-year fracture that never properly healed and all he complained about was a little back pain caused by farm work. It really puts things in perspective."

The project involved a large number of military doctors and nurses from the Pacific partner nations who treated more than 400 patients in just a few hours. "There is no doubt these people are doing great things here today," said COL Stephen Maloney, USMC, deputy director, humanitarian/civic assistance projects. "We are absolutely out here to help the local community." Maloney said this project, along with others conducted in the past weeks, is part of an overall theater security cooperation initiative. These projects are designed to foster ties between the Southeast Asian nations and prepare them for real-world contingencies such as the December 2004 tsunami relief effort.

"We are helping to provide the essential (military to military) relationship development that we need in the region," he added.

The medical assistance here provided Pacific partner nations a chance to work together in an operational environment and help people in need. "(It) feels great to help and learn from our partners and learn more about their cultures," said Singapore MSGT Tan Shaotheng. "This operation has been well organized and the flow has been smooth. It is very well done."

The medical professionals did not just treat the patients' injuries, they also collected valuable data that were sent to local healthcare facilities and referred the patients for follow-on healthcare. "Sure, we can help them here and now. But, we also need to be concerned about the follow-on care," Maloney said. "The data collection is just as important as the medical care."



The tripod data system personal digital assistant is used to collect a patient's examination information and wirelessly sends it to a database that will disseminate and store the information.

Photo by CPL R. Drew Hendricks, USMC, Marine Forces Pacific

Those involved in the project continued working long into the hot and humid day, handing out eyeglasses to those who have never seen clearly, fitting the old with canes, and checking the health and comfort of the young. Working with translators, the staff did not quit until the last person's sheet had been filled out completely.

The sentiment among the medical professionals was of not doing enough. Despite the language barrier, those receiving treatment smiled and laughed alongside their caregivers who came from all corners of the Pacific. Even those who were weakened from pain expressed their gratitude. "I think they appreciate our help," Shaotheng said. "They need medical attention and we are happy to provide it for them." ✍

—Story by CPL R. Drew Hendricks, Marine Forces Pacific (FWD), Prachuap Province, Thailand.

New Medical Department Flags

CAPT William M. Roberts, MC, received his Bachelor of Arts degree from Princeton University in 1975 and his Doctor of Medicine degree from The George Washington University in 1979. Dr. Roberts attended medical school under the Armed Forces Health Professions Scholarship Program.

Dr. Roberts was commissioned into the Medical Corps in May 1979 and completed his surgical internship at Naval Regional Medical Center, San Diego.

He started his career as Senior Medical Officer aboard USS *New Orleans* (LPH-11) and USS *Durham* (LKA-114). He followed these deployments with an assignment to Naval Medical Clinic, San Diego.

He served as Senior Medical Officer at Naval Station, San Diego and as Clinic Director at both the Naval Training Center and the Marine Corps Recruit Depot. He matriculated into the University of Chicago Emergency Medicine residency, serving as Chief Resident during his last year of training. Upon completion of residency in 1988, Dr. Roberts was assigned to Naval Medical Center San Diego. In 1991, he received orders to U.S. Naval Hospital, Guam, and returned to Naval Medical Center San Diego in October 1993. In August 1995, he received additional orders as Commanding Officer, Medical Treatment Facility, USNS *Mercy* (T-AH 19). He subsequently served as Deputy Commander, Naval Medical Center San Diego from August 1998 until November 2001. From November 2001 until May 2003, he was assigned as Force Surgeon for Commander, Naval Surface Force U. S. Pacific Fleet, in Coronado, CA. Dr. Roberts then served as commanding officer, Naval Hospital Bremerton from June 2003 until May 2006. He currently serves as Deputy Director, Medical Resources, Plans and Policy Division in the Office of the Chief of Naval Operations in the Pentagon.

CAPT Roberts' awards include the Legion of Merit (three awards), Meritorious Service Medal (two awards), Navy Commendation Medal (two awards) and Navy Achievement Medal. He earned a Master in Business Administration degree from Edinburgh Business School, Edinburgh, Scotland in November 1999. ⚓



CAPT Richard Vinci was born in Chicago, IL. He enlisted in the Navy in 1967, completing Dental Technician "A" School in April 1968. His enlisted duty stations included Naval Dental School, Bethesda, MD, and Marine Corps Air Station, New River, NC.

Honorably discharged as a second class petty officer, he returned to William Carey College, Hattiesburg, MS, and graduated in 1973 with a Bachelor of Arts Degree in chemistry. He entered Louisiana State University School of Dentistry, graduating in 1977 with a D.D.S. degree. His assignments included Naval Regional Dental Center, Jacksonville, FL. In 1979, he was assigned aboard the USS *Bryce Canyon* (AD-36), followed by duty at the Naval Regional Dental Clinic, Pearl Harbor. While there Dr. Vinci was selected for advanced training in operative dentistry at the University of Michigan, graduating in 1985 with a Master's Degree in restorative dentistry. He was then assigned to Naval Dental Center, Orlando, FL. He then served in Okinawa, Japan as the Executive Officer of the 3rd Dental Company, then returned to Orlando for 18 months. While there, he received assignment as Head, Professional Standards, Bureau of Medicine and Surgery in 1991.

In June 1994, Dr. Vinci became Director, Branch Dental Clinic, Washington Navy Yard, National Naval Dental Center. He was assigned as XO, Naval Dental Center, San Diego until June of 1999. He then served as CO, 1st Dental Battalion/Naval Dental Center, Camp Pendleton, CA, followed by an assignment as CO of Naval Dental Center, Great Lakes, IL. In 2005 he transferred and assumed duties as Deputy, Naval Medical Inspector General, Bureau of Medicine and Surgery. CAPT Vinci is currently Acting Naval Medical Inspector General, Bureau of Medicine and Surgery.

CAPT Vinci's awards include: Legion of Merit (2), Meritorious Service Medal (3), Navy Commendation Medal, and the Navy Achievement Medal. He is a member of the American Dental Association and the Academy of Operative Dentistry. Captain Vinci is a fellow of the American Board of Operative Dentistry, American College of Dentists, and the International College of Dentists. ⚓



Moore Assumes Command of MTF/EMFK

CAPT Kevin D. Moore, MC, assumed command of Medical Task Force/Expeditionary Medical Facility Kuwait (MTF/EMFK) from CAPT C. Forrest Faison III, MC, in a ceremony at Camp Arifjan's Zone 1 chapel 4 May 2007. The ceremony seamlessly blended Navy and Army traditions of the guidon with the ship's bell ringing aboard and ashore the official party.

After arrival of the official party, EMFK's color guard paraded the colors. HN Clay Casassa sang the National Anthem. The invocation was given by LCDR Richard Moon, CHC. MTF deputy commander CAPT James J. Ware, MC, introduced the guest speaker, MGEN Thomas D. Robinson, Commander 377th Theater Support Command (FWD).

Robinson recounted Faison's role in establishing Medical Task Force Kuwait and bringing together Army and Navy commands, which include eight outlying Troop Medical Clinics. Robinson recounted impressive statistics under Faison's tenure, 1,400 urgent care visits, 51,000 medical and dental examinations, 5,000 X-rays, 76,000 prescriptions, 800 surgeries and 35,000 laboratory tests," said Robinson. "It says an awful lot about CAPT Faison's leadership of the personnel in this room." Robinson noted Faison's commitment to personnel training accounting for nearly 6,000 hours in various aspects of medicine, from emergency medical technician and to sick call screener, to complex MASCAL (mass casualty) drills. "You don't stay on top of your game without training," said Robinson. "All of a sudden it came to bear we had several (actual) MASCALS in a short amount of time. It showed the training and made the difference."

Robinson then turned his attention to CAPT Moore. "We have a new commander coming in. His leadership has been tested; it's true. I know he'll continue to provide excellent support to our troops in the AOR (area of responsibility)."

At the conclusion of Robinson's remarks, CAPT Faison was presented with a photo board of the 16 units that make up Medical Task Force Kuwait. Within the ring of photos was the Task Force guidon. MTF and EMFK command coins were embedded in the bottom of the frame. Designed by MTF Command Master Chief CMDCM(FMF/SW/AW) Gerardo Ramos the board was built at Camp Arifjan's wood shop by EMFK corpsmen.

Visibly moved by the gift, CAPT Faison began his remarks. "In the past 12 months I've learned one thing: patriotism, heroism, and selfless service are not dead, but alive and well with you and all the men and women who serve."

Faison awarded Navy Commendation Medals to MAJ Brian Farris of MTF and HM3 Jenna Nowaczyk of Forward Deployed Preventive Medicine Unit South. Then, Faison read his orders relinquishing command, and Moore read his, assuming command. The guidon was passed to MGEN



Incoming Medical Task Force/Expeditionary Medical Facility Kuwait CO, CAPT Kevin D. Moore (left), and outgoing commander CAPT C. Forrest Faison III, listen to MGEN Thomas D. Robinson, commander 377th Theater Support Command (FWD) give his remarks during the change of command ceremony. Photo by MC1(SW) Cindy Gill, Camp Arifjan, Kuwait, Public Affairs

Robinson who passed it to Moore signifying the transfer of command.

"I hope to continue [CAPT Faison's] tradition 'One Team, One Purpose,'" said Moore. "To this end I plan to focus on communication, coordination, and the continued professional care I've seen evidenced in my brief orientation. Duty, honor, courage, and commitment are not words to you but a way of life," said Moore. ✍

—Story by MC1(SW) Cindy Gill, MTFK/EMFK Public Affairs, Camp Arifjan, Kuwait.

Recon Doc Recognized for Valor

In times of conflict, service members may be exposed to negativity and the very worst in people. Also in times of conflict, in the face of danger, a true American hero may be born.

HM1 Brian Thurmond, a special amphibious reconnaissance corpsman with recon platoon, Battalion Landing Team 3/1, was meritoriously promoted 2 May through the Navy Meritorious Combat Advancement Program for his actions while deployed to Iraq last year.

The program was created for commanders to nominate Navy personnel ranking E-1 through E-5 in recognition of extraordinary actions performed while engaged in, or in direct support of combat operations, much as a combat meritorious promotion is done for Marines.

During a 14 February 2006 firefight, Thurmond rendered care to a wounded interpreter while under fire with no regard for his own safety. He continued to care for the wounded until the interpreter could be evacuated, recalls GSGT David Lind, Recon platoon sergeant. "His conduct and efficiency



HM1 Brian Thurmond (center) during his promotion ceremony on the USS Bonhomme Richard (LHD-6) flight deck. Photo by HM1 Roddy D. Robinson, USN, 13th MEU

in times when he was needed the most was impressive,” said Lind.

Thurmond, who has been a corpsman for 12 years, has been a special amphibious reconnaissance corpsman (SARC) for 5 years. “The training is very hard and long training. It usually takes around 18 months or longer to get through all the training,” said Thurmond.

Training to become a SARC begins with Field Medical Service School followed by a Basic Reconnaissance Course, Marine Combatant Diver school and Airborne Basic school. Lastly, corpsmen have to complete the Amphibious Reconnaissance Corpsmen Course and the Special Operations Medicine Course to earn the job title of SARC. “The training given in the courses makes it so that the corpsman in a platoon can perform all basic tasks just as the Marines would,” said Thurmond.

Thurmond’s actions and conduct while in Iraq did not go unnoticed. Lind and platoon commander CAPT Jason Armas felt Thurmond’s actions should be formally recognized. “We felt that Thurmond was more than deserving of being recognized for the outstanding service member he is,” said Lind. “He set the example.”

The confident but humble “Devil Doc” credits his comrades for his success. “I know that without the leadership and the fellow members of my platoon, I never would have made it this far,” said Thurmond. “We put our lives on the line for each other and there’s no greater group of guys to be doing it for.”

Thurmond is currently embarked on a Western Pacific deployment with Battalion Landing Team 3/1, and the 13th Marine Expeditionary Unit. ✍

—Story by LCPL Timothy M. Stewman, 13th Marine Expeditionary Unit.

Navy Officer Earns Army’s Medical Badge

Landstuhl, Germany — Charles B. Pasque may appear to be out of uniform, but the Navy officer has indeed earned the right to wear the badge pinned above his left breast pocket.

Last month, Navy CDR Pasque was one of 26 service-members to receive the Army’s prestigious Expert Field Medical Badge (EFMB) after a competition at Grafenwöhr Training Area. He was the only sailor in the group to earn the honor and could be the first naval officer ever to receive the award since the Army approved the badge in 1965.

To put Pasque and the other EFMB recipients’ achievement in perspective, Armywide, the badge’s pass rate for fiscal 2007 is 8 percent, according to an Army EFMB Web site.

Candidates must score at least 75 out of 100 on a written test, successfully perform medic skills during combat scenarios on three training lanes, conduct day- and night-land navigation, and finish a 12-mile road march in less than three hours, carrying a weapon and 35-pound rucksack.

Of the 262 candidates vying for the badge at Grafenwöhr, only 10 percent passed.

Age 44 at the time, Pasque said he was twice the age of most his fellow competitors.

Pasque wears the badge proudly and had fun—at least once—during the grueling testing. On one of the training lanes, competitors had to react to sniper fire by returning fire with blank rounds.

“I almost unload my whole clip on this guy, and the evaluator goes, ‘I think you got him, sir,’” Pasque said. “I looked up at him and said, ‘You don’t understand. I don’t ever get to do this stuff.’ He smiled with me, and the sniper’s over there just cracking up.”

But how did a Navy officer—an orthopedic surgeon, no less—end up in the middle of Europe competing for a medical badge normally reserved for soldiers?

Pasque is in the midst of a 12-month stint as a Navy reservist at Landstuhl Regional Medical Center. In his civilian life, Pasque is an associate professor in the Department of Orthopedic Surgery and Rehabilitation at the University of Oklahoma Medical Center.

Around January, a general surgeon talked Pasque into trying for the badge. Some 60 sailors initially were interested in trying to earn the badge, but by the time the competition rolled around, only three sailors assigned to Landstuhl made the trip.

Pasque was the only one to receive the badge.



Navy CDR Charles B. Pasque was the only sailor to earn the Army’s Expert Field Medical Badge during last month’s testing in Grafenwöhr, Germany. Photo by Steve Mraz

Maj. Gen. Mark Hertling, the former U.S. Army Europe deputy chief of staff for operations, pulled Pasque out of the formation of the 26 EFMB recipients because Hertling believed Pasque was the first Navy officer to earn the badge. "He was very nice," Pasque said of Hertling. "He took me out in front and said, 'This should be motivation for you soldiers. If a Navy guy can do it, you can do it.'"

—By Steve Mraz, *Stars and Stripes, European edition*, Wednesday, 13 June 13, 2007. "Used with permission from Stars and Stripes. © 2007 Stars and Stripes."



On Friday, 20 April 2007, CDR Maureen Pennington, NC, from Naval Medical Center San Diego was awarded the Bronze Star for meritorious achievement in connection with combat operations involving conflict with an opposing force, while serving as CO, Charlie Surgical Company, Combat Logistics Battalion-5, 1st Marine Logistics Group (Forward), I Marine Expeditionary Force (Forward), from February 2006 to September 2006. Her proactive foresight served her well in order to communicate intent and expectations to her subordinates.

Her first change was adopting a tracking system which served to increase the availability of supplies from 1,400 to over 5,000 line items, a turnaround time from an average of 7-12 weeks to 9-14 days, and an internal tracking system to visualize where in the supply chain the items were located. This was achieved while located in the austere combat environment of Camp Fallujah, with subordinate elements in Taqaddum and Ramadi. As well as being subject to indirect fires in all three locations, these were the largest and most engaged Level II surgical units of 6 in the I Marine Expeditionary Force battle space. Over 1700 Level II or above patients were seen, of which over 600 patients required surgery before being evacuated.

CDR Pennington's exceptional planning and ingenuity ensured Charlie Surgical was prepared to handle large scale casualties, which proved critical in the months to come. Despite a high number of patients with blast wounds from improvised explosive devices, she help maintain an unprecedented 98 percent of combat wounded survival rate. Her dedication to excellence in combat casualty care established a benchmark for medical support of Marine combat operations.

Navy RDML Christine M. Bruzek-Kohler has been nominated for appointment to the grade of rear admiral. Bruzek-Kohler is currently serving as chief of staff, program executive officer, N-09, Bureau of Medicine and Surgery (BUMED) and Director of the Nurse Corps, Washington, DC.



Keeping it in the Family...from one generation to the next, LTJG Tom Shirk, USN, (Ret.), and his wife, Kathleen, do the honor of promoting their son, Stephen Shirk from ENS to LTJG, NC. LTJG Shirk transferred to NHB after serving 8 months on deployment to Expeditionary Medical Facility Kuwait, primarily at Camp Arifjan as a In-Patient/Intensive Care Unit/Ward nurse. The parent promoting principle didn't quite extend between Tom and his dad Wayne, who retired in the 1960s after 20 years service from the early days of WWII and ending at a tiny Naval Air Base at Olathe, KS. But Tom has been very active in the career of his son, for Stephen, not only in the Navy medicine field, but as an inspiration and role model to emulate. Stephen followed his dad through his higher education years by also attending University of Kansas, and then on into the military, where his commissioning officer was also one very happy father. "I couldn't be prouder," stated the elder Shirk, Naval Hospital Bremerton Infection Control Coordinator. "I'm also happy my uniform fit and the shoes weren't too yellowed with age!"

—Story and photo by Douglas H. Stutz, *Naval Hospital Bremerton Public Affairs*.

This piece, written by then HM2 Mark J. McClellan, was first published in the October 1981 issue of U.S. Navy Medicine. Countless times since then, we have received requests for copies. The passage of time has in no way diminished its message.

Skate Rate

“All you corpsmen ever do is skate! You guys never do any work; I wish I had an easy job like yours!” We hear those comments every day and put up with endless kidding about our “easy” job. I hope to clear up some of the myths about my job and just how easy it is at times. A machinist’s mate once told me that if you didn’t have greasy hands you were in a “skate rate.” And we all know that corpsmen never get their hands dirty.


But just how easy is it being a corpsman? Working around pain, suffering, and, many times, death, has never been easy for me. I had been a corpsman for 2 months when a 3-year-old boy died in my arms one Christmas Eve. He died of Tay-Sachs disease; it’s incurable and only affects very young children. I was about to become a father myself.

A 38-year-old woman who had undergone several operations to arrest cancer lost the battle against that disease on her birthday. She left behind a husband and five children, the youngest of whom was 18 months. Her husband was a Marine master sergeant. I had pictured all Marines as “towers of strength” incapable of showing any emotion. When I saw him in tears that day, I realized that the men of our toughest fighting outfit were also very human, and that I was ignorant in assuming otherwise. I had a lot to learn.

When I was assigned to the Marines, one of my first duties was on an ambulance crew. My first run was to the grenade range where a drill instructor and a recruit were killed by a hand grenade. The scene was the most sickening thing I’ve seen to this day. There were some very lucky recruits though, because a heroic drill instructor gave his life so that they wouldn’t be killed. And then there was the recruit who ended his life with a rifle bullet through his head, the pilot who ejected out of his aircraft when it went sideways and was skipped like a pebble 300 yards down the runway, and the baby who was beaten by his parents because he wouldn’t stop crying. He died. I could go on, but I hope I’ve made my point.

Many people see us when we are not working. To tell the truth I’d rather not have to work because when I have to work, one of my shipmates is either sick or injured. Even though I have been able to accept it, I have never gotten used to seeing people hurt. If a person thinks my job is “skating,” why don’t they try it? Grease and blood both wash off, but do you remember the times and circumstances that your hands were dirty? I can recall every time I’ve had blood on my hands and even though it washes off, it’s hard to forget.

I love my job and am proud of what I do. I put up with ignorant comments every day about my job, but to be called “Doc” means the world to me, especially when a shipmate would rather see his doc than to go to the dispensary.

So if I skate or am out of work, it’s your fault. (Keep it that way, please.) But should you decide to bring your business my way, I am ready and waiting to serve you. 

The Society for the History of Navy Medicine (Established May 2006)

Vision Statement:

The Society for the History of Navy Medicine is an international association of people interested in the history of all aspects of medicine as it relates to the maritime environment.



Mission Statement:

The mission of the Society is to promote the study, research, and publication of all aspects of maritime medicine.

The Society will be a means of “mutual support” and communication for people of all countries—civilian, military, academic, independent scholar, medical practitioner—who are interested in the topic.

Joining the Society:

Anyone wishing to join the Society should e-mail CAPT Thomas Snyder, MC, USNR (Ret.) at thomaslsnyder@gmail.com. In your message please include your name, rank (if military), and list any specific interest/specialty you might have in Navy medical history (e.g., Civil War medicine, Navy nursing, hospital ships, hygiene, etc.)

Call for Papers—2008 Meeting

The Society for the History of Navy Medicine invites submission of abstracts for papers for its Second Annual Papers Session, to be held during the 10–13 April 2008 meeting of the American Association for the History of Medicine, in Rochester, NY.

Papers may address any aspect of the history of medicine as it relates to navies and/or the maritime environment (including air, space, and sub-surface). Historians, graduate students, and medical practitioners are encouraged to submit proposals.

Deadline for submission of your 250-word abstract is 15 November 2007. Electronic submission is preferred, to thomaslsnyder@gmail.com. Hard copy submission by the same deadline may be sent to:

Thomas L Snyder, MD
Captain, Medical Corps, U S Navy, Retired
Executive Director
The Society for the History of Navy Medicine
131 El Camino Real
Vallejo, CA 94590-3464



Atlantic Ocean. HM3 Michael Mitchell, assigned to amphibious assault ship *USS Nassau* (LHA 4), stitches a head laceration. *Nassau* is currently underway conducting training operations for ULTRA E inspections. March 2007. Photo by MC2 Andrew King, USN



Rota, Spain. AB2 Russel Armand and HM2 Dan Gomez carry a crash "victim" from the scene of a mock accident during the "Day of the Dead," a project conceived by Rota's David Glasgow Farragut High School students to promote awareness of drunk driving. April 2007. Photo by MC2 Glen Dennis, USN



Mina Salman, Bahrain. Commander, U.S. Naval Forces Central Command/U.S. 5th Fleet Command Master Chief Kelly Schneider and CMC Leonard Gordon, *USS Whirlwind* (PC-11) command chief, talk to Iraqi navy CWO2 Abdul Majeed during a tour of the ship. Majeed, the senior noncommissioned officer of the Iraqi navy's surface component, also toured *USS Anzio* (CG-68) with Schneider. February 2007. Photo by MC2 Christopher T. Smith, USN



Panama City, Panama. LTJG Brian Blackburn (left) and HM1 Jose Ramirez (right), assigned to *USS Springfield* (SSN-761), paint high chairs during a community relations (COMREL) project at the Hogar Divino Niño Orphanage in Panama. March 2007. Photo by LTJG Andrew Haley, USN



Isabela, Philippines. CDR David Lu performs delicate cataract surgery on a patient while members of the Philippine Navy medical team, along with Navy nurses and hospital corpsman, assist and observe. The cataract surgery was a service provided by a Medical Civic Action Project (MEDCAP) held at two locations in Isabela. The Philippine and U.S. cataract team provided the no-cost procedure at Basilan General Hospital during the Cooperation Afloat Readiness and Training (CARAT) exercise series. June 2007. Photo by MC1 Dave Gordon, USN



Mondi, Afghanistan. LCDR William C. Ashby, MSC, treats an Afghan man during a medical civic action program. Ashby is a physician assistant and medical officer with Provincial Reconstruction Team Nuristan. May 2007. Photo by PFC Daniel M. Rangel, USA



Naval Hospital Bremerton. CAPT Carol Morones, Naval Hospital Bremerton Director of Patient Support, is joined by ENS Lindsay Routt, from NHB's MS-5, to cut the birthday cake as the most senior and junior Nurse Corps officers at NHB. On 13 May the Navy Nurse Corps celebrated its 99th birthday.

Photo by Douglas H. Stutz, Naval Hospital Bremerton Public Affairs



The Conaway Cemetery at Naval Medical Center Portsmouth served as the backdrop for the annual Memorial Day ceremony to honor service members. The cemetery is the final resting place for more than 850 fallen soldiers, sailors, and Marines from seven countries as well as both Union and Confederate service members. Placing the wreath are Isaac and Margaret Spears, Presidents, Fleet Reserve Association. Photo by MC James Holcroft, USN



Washington, DC. Navy medicine commemorated the 109th anniversary of its Hospital Corps and paid tribute to sailors who provided medical and dental care to their fellow service members with a wreath-laying ceremony at the Navy Memorial. The wreath is a token of honor to all hospital corpsmen, past, present, and future. 15 June 2007. Photo by Christine Mahoney, BUMED Public Affairs

“Navy Dental Corps Celebrating 95 Years . . Always Ready.”

CAPT Andrew D. Peters, DC, USN

Navy dentistry has matured into a world-class dental healthcare organization setting high standards for excellence, research, health promotion, and prevention, and highlighted by 95 years of exceptional performance and personal sacrifice. Structured to provide optimum support and focused on mission, we are now well positioned to respond to the challenges of the 21st century.

The Formative Years

The idea of a distinct Navy Dental Corps had been swirling around the Navy medical community as far back as the 1870s. In the 1870 annual report to the Secretary of the Navy, the Chief of the Bureau of Medicine, William Wood, praised the importance of “dental science” and recommended the hiring of permanent, trained dental officers. To some extent, Congress took heed and a dental service was established at the medical department of the U.S. Naval Academy in 1873.

Not until 22 August 1912, during William Taft’s presidency—a man with a passion for sweets—did Congress pass the bill and establish the Navy Dental Corps. Our legacy had begun.

The Secretary of the Navy was authorized to appoint no more than 30 acting “assistant dental surgeons.” In October 1912, Emory Bryant and William Cogan became the first two dental officers to enter active duty. One year later, the Surgeon General reported to the Secretary of the Navy that the Medical Department now had the ability to provide dental care to recruits who would otherwise be rejected.

In World War I, the Dental Corps grew from 35 to 500 active duty dental officers. Most were assigned to ships or overseas activities. Thirty dental officers served with the Marines in France; two were awarded our nation’s top honor. LCDR Alexander G. Lyle received the Medal of Honor while serving with the 5th Regiment, U.S. Marines; LTJG Weeden E. Osborne, the first Navy officer to meet death fighting overseas in the war, was awarded the Medal of Honor for heroism while serving with the 6th

Regiment, U.S. Marines. The torpedo boat destroyer USS *Osborne* (DD-295) was commissioned in his honor in December 1919.

The value of uniformed dentists to the Navy was now universally recognized and a period of steady growth ensued. Early in 1923, two significant milestones occurred: the establishment of the U.S. Naval Dental School and the creation of a dental division in the Bureau of Medicine and Surgery. There were 150 dental officers on duty at the time. During this era, Navy dentistry began focusing heavily on prevention of disease, unique at the time and a quality that distinguishes our corps today. Navy dentists demonstrated their skills throughout the 1920s and 1930s in Navy and Marine operations in Haiti, Nicaragua, and China. By 1939, 225 dental officers served at 22 major dental facilities ashore and afloat.

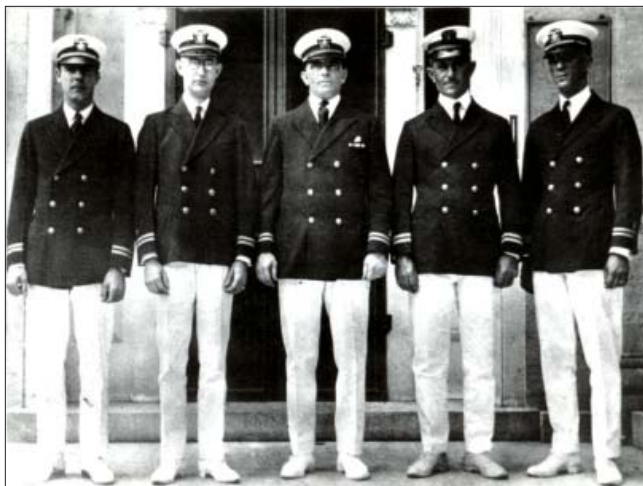
When Japanese forces attacked Pearl Harbor on 7 December 1941, 759 dental officers were on active duty at 347 dental facilities. Two Dental Corps officers were killed in the attack on Pearl Harbor, LCDR Hugh R. Alexander, aboard USS *Oklahoma* (BB-37) and LCDR Thomas E. Crowley, aboard USS *Arizona* (BB-39). Less than a month later, the Surgeon General directed all dental officers to become proficient in the treatment of casualties, assist in sick bays and operating rooms, administer supportive therapy, and give anesthetics.

As the United States ramped up for world war, the Dental Corps initiated a massive rehabilitation program in May 1942 for incoming recruits to prepare sailors and Marines prior to transferring them overseas.

As the world fought, many dental officers were killed in action aboard warships, in major battles at Guadalcanal, Tarawa, Saipan, and Iwo Jima and in “hell ships” as POWs. For their heroic efforts, 93 received personal awards including the Silver Star, Legion of Merit, Navy and Marine Corps Medal, and the Bronze Star.

A Powerful Program

In 1942, the Naval Dental School was commissioned as part of the National Naval Medical Center, Bethesda. Thus



First Graduating Class of the U.S. Naval Dental School, Washington, DC, 1923 (l to r: J.W. Baker, R.S. Davis, A.W. Chandler, W.C. Carroll, and R.H. Fladeland.) Notable among these graduates was LT Alfred Chandler who would later become the dentist to President Franklin Roosevelt and Chief of the Navy Dental Corps.

began a journey of excellence and today the Naval Dental School is home to one of dentistry's premier post-graduate education programs. On 18 December 1942, President Roosevelt approved the rank of rear admiral for our first flag officer, Medal of Honor recipient, Alexander G. Lyle.

At war's end in 1945, 7,026 dental officers served on active duty and 1,545 dental facilities were in operation. Dental technicians on duty numbered 11,339 and there were 1,200 "dental" WAVES. Notable among these pioneers was LT Sara G. Krout, the first female dental officer in the armed forces.

Recognizing their leadership and management abilities, dental officers were eventually assigned command of their own facilities. On 13 March 1946, the first Navy dental clinic was commissioned under command of a dental officer at the Naval Shipyard, Brooklyn, NY. In 1948, dental technician training was formalized at Naval Training Centers, located at Great Lakes, IL, and San Diego.

In June 1950, President Truman ordered our armed forces into action in Korea. As the 1st Marine Division deployed, dental officers and dental technicians provided dental and medical support forward on the battlefield. Korea marked the first time in history that enlisted men of the Navy wore dental rating badges into combat. One such sailor was DN Thomas A. Christianson, awarded the Navy Cross posthumously for his gallant efforts while serving with the 1st Amphibious Tractor Battalion. At the peak of the action, 1,900 dental officers and 4,700 technicians were on duty. Dental personnel served heroically: 15 dental officers earned personal commendations including the Silver Star, Bronze Star, and Commendation Ribbon with Combat V.

Revolutionizing the field of dentistry worldwide, researchers at the Naval Dental School developed pioneer

models of the dental air turbine hand piece and ultrasonic vibrating instruments. Recognizing a tremendous leap forward for the dental profession, these prototypes are now displayed at the Smithsonian Institution.

By the beginning of the 1960s, Navy dentistry operated from 160 shore-based facilities and aboard 156 ships. To support Marine Corps operations, Navy dentistry developed and deployed nine innovative mobile dental units on trailers, each with more powerful rotary instruments, a field x-ray unit, and a film processor. These field dental capabilities proved their worth when a detachment of the 3rd Dental Company deployed with Marines to Vietnam in June 1965. Many more dental teams would follow. Between 1965 and 1973, dental personnel from the 1st, 3rd, and 11th Dental Companies, along with detachments of the 15th Dental Company, deployed to Vietnam in support of Marine Ground and Air Combat Units. In addition to caring for Marines, dental participated in many civic action programs and trained Vietnamese dentists as part of the "Vietnamization" program. At the peak of the Vietnam War, one-fifth of the Dental Corps—420 dental officers and 790 dental technicians—were attached to Marine units.

Modern Operations

In 1975, the nuclear powered aircraft carrier, USS *Nimitz* (CVN-68) was commissioned with the most modern and capable dental facility afloat, supporting seven dental operating rooms, a prosthetic laboratory, central sterilization room, x-ray suite, and preventive dentistry room. When a Navy jet crashed on *Nimitz's* flight deck on 26 May 1981, killing 14 and injuring 48, dental personnel played a critical role in the mass casualty response.

The tragic Beirut bombing in 1983 of Marine barracks of Battalion Landing Team 1/8, 24th Marine Amphibious Unit, left 241 American servicemen dead. The only on-scene Navy physician was killed, along with 18 hospital corpsmen. Two dental officers assigned to the 24th Marine Amphibious Unit coordinated emergency trauma care with 15 hospital corpsmen, treating 65 casualties in the first 2 hours following the explosion. Both were later awarded Bronze Stars for their leadership and emergency medical services. Additional dental personnel aboard USS *Iwo Jima* (LPH-2) joined medical teams ashore to provide care and support for survivors.

In July 1984 and 1987, hospital ships USNS *Mercy* (T-AH 19) and USNS *Comfort* (T-AH 20) were placed in service with 1,000 beds and 12 operating rooms plus spaces for comprehensive dental services including two operating rooms, four dental treatment rooms, and a dental laboratory. In the mid-1980s, when the battleships *Iowa* (BB-61), *New Jersey* (BB-62), *Missouri* (BB-63), and *Wisconsin* (BB-64) were re-commissioned, dental spaces

were upgraded to provide high quality dental support under way.

In March 1986, the Naval Postgraduate Dental School moved into its new spaces in Building 1 on the National Naval Medical Center campus. What began as the Dental Department of the Naval Medical School in 1923 has evolved into a state-of-the-art, fully accredited, postgraduate dental school recognized as one of the best in the world.

With the Iraqi invasion of Kuwait in August 1990, and the commitment of U.S. forces to the region, detachments of the 1st, 2nd, and 3d Dental Battalions deployed in support of the 1st and 2nd Marine Divisions. Dental Battalion personnel ultimately established 21 dental clinics in three countries, in such places as the Marine airfield at Sheik Iza, Bahrain, the Port of Jubail in Saudi Arabia, and in the desert sands of northern Saudi Arabia and Kuwait. The hospital ships *Comfort* and *Mercy* brought their dental assets to the war effort, and active and reserve dental personnel were deployed with each of the three Fleet Hospitals in-theater. In all, more than 90 dental officers and 300 dental technicians deployed in support of Desert Shield and Storm.

In 1992 civil unrest in Somalia erupted into all-out tribal war. Marines of the 1st Force Service Support Group arrived in Mogadishu, and 1st Dental Battalion personnel provided dental care for Marines in that country. Supporting the State Department's peacekeeping efforts, they also provided humanitarian dental care to Somali citizens.

In June 1998, the Dental Corps answered the call in Port-au-Prince, Haiti. A dental officer commanded the medical task force composed of 65 personnel from the Navy, Marine Corps, and Army. Over the next 6 months the task force provided advanced health services support to assigned U.S. Support Group military personnel and UN personnel, while conducting humanitarian assistance missions throughout the country.

The terrorist attacks of 11 September 2001 changed life in America. At the Pentagon, Tri-service Branch Dental Clinic personnel were among the first responders.

Operation Iraqi Freedom commenced on 19 March 2003. Contributing to this campaign were over 500 dental officers and technicians assigned from forces afloat, Navy dental commands, dental battalions, and Seabee battalions.

On 3 November 2003, CAPT Carol I. Turner took the helm as the 34th, and first female, Chief of the Navy Dental Corps.

In 2004, the Surgeon General of the Navy announced the integration of medical and dental commands, keeping with the CNO's vision to make better use of uniformed personnel within the human capital strategy. The Navy-wide integration of 106 dental treatment facilities with




Camp Fallujah, Iraq, 2005. Dental Detachment with Fallujah Surgical Company (l to r: HM3 Devon Gilreath, LCDR J. Joyce, HM3 Kristen Vinson, HN Mikal Shearin, Detachment Commander, CAPT Andy Peters)

medical was complete in 2005. The Navy's four Marine dental battalions remained as dental commands.

On 5 January 2005, dental officers and technicians departed San Diego aboard USNS *Mercy* for a 5-month deployment to support tsunami-devastated regions of Southeast Asia as part of Operation Unified Assistance. In support of FEMA's response to Hurricane Katrina, dental personnel from the National Naval Medical Center deployed with the USNS *Comfort* to provide humanitarian aid to the devastated regions along the Gulf coast.

In July 2005, the Hospital Corpsman (HM) and Dental Technician (DT) rating merger was approved by the CNO to better support our operational forces by ensuring all enlisted medical personnel have the same baseline training and enhanced flexibility in the utilization of all personnel. Nearly 3,000 DTs merged with 24,000 HNs ending 58 years of the DT rating.

In December 2005, Program Budget Decision (PBD) 712 required an immediate conversion of 1,772 Navy medicine billets. Navy dentistry's portion was 103 dental officers. Following PBD 712, the CNO directed a study that led to 192 additional billet losses through FY09. Most recently, the Medical Readiness Review chaired by the Office of the Secretary of Defense, Property and Equipment (OSD P&E) will likely provide the opportunity for additional conversions that will affect the medical departments of all three military services.

This year, the Navy Dental Corps celebrates 95 years of tradition, progress, and opportunity. As it has since its origin on 22 August 1912, the Dental Corps maintains high operational readiness in support of the Navy and Marine Corps while responding to the exponentially increasing challenges of the 21st century. 

Dr. Peters is M122, Dental Plans and Policy, BUMED, Washington, DC.

HMS *Amethyst's* Angel of Mercy

Jan K. Herman

It was as quiet a day as could be expected on the Yangtze River in the middle of a civil war. HMS *Amethyst* had just departed Shanghai the previous day and was heading upriver toward Nanking to relieve HMS *Consort*, a symbol of British presence and protection for British citizens and diplomats in the Chinese capital. Despite warnings that opposing forces occupied the river's north and south banks, the 299-foot-long British frigate steamed on, a white ensign and Union flag flying from her jack staff, no doubt providing immunity to a declared neutral.

Such was the expectation as British gunboats had plied Chinese waters with near impunity since Britain had forcibly opened China to trade and exploitation in the mid-1800s. But the global situation was different now. It was post-World War II China, and the brutal conflict between Nationalists and Communists was now reaching its denouement. Mao Tse Tung's armies had conquered almost all north China and were now poised to cross the Yangtze and finish what they had started more than a decade before invading Japanese troops forced an intermission.

It was approximately 8:30 a.m. on 20 April 1949. LCDR Bernard Skinner, the skipper of *Amethyst*, had alerted his crew that they were about to pass a reported Communist artillery battery on the river's north bank. Suddenly the ship took small arms fire but an increase in speed soon took the vessel out of danger. Then, just 9 miles farther upriver, in the vicinity of Rose Island, 37mm armor-piercing shells from another Communist emplacement punched their way through the warship's steel hull, inflicting both damage and casualties. One shell destroyed her wheelhouse, jammed the starboard engine telegraph, and mortally wounded a sailor. With the ship's helmsman also injured, the stricken vessel ran hard aground on a mud bank about 150 yards off Rose Island, 40 miles downstream from Nanking.

The situation had suddenly turned harrowing. Even before the guns on *Amethyst* could reply, more shells hit the bridge killing and wounding nearly all personnel stationed there, including the ship's commanding officer. Aground and unable to defend herself, the ship offered a stationary target for Communist gunners for the next hour and a half.

Chaos reigned below decks as incoming artillery wrecked the power room, disabled the gyrocompass, radio, and knocked out essential electrical circuits. A direct hit then killed the gun crew on the fo'c'sle. As Surgeon-Lieutenant J.M. Alderton and the sick-berth attendant worked feverishly to treat the growing number of wounded, another shell exploded nearby killing both of them instantly. By the time the shelling slackened at 11:30 a.m., 21 officers and men were dead and another 28 lay wounded. Among the mortally injured were the commanding officer, LCDR Skinner, and the Chinese pilot responsible for guiding the ship up the Yangtze.

Although wounded himself, the gunnery officer, LT Geoffrey Weston, now in command, ordered the wounded to be moved to the safest part of the frigate. He also authorized crewmembers to abandon ship and head for shore—if they could swim. An attempt to evacuate the most seriously injured aboard a small boat met with disaster when enemy fire killed two men. Despite the damage already inflicted, *Amethyst's* radioman managed to send a signal to all ships in the vicinity, "Under heavy fire, am aground. . . . Large number of casualties." With the frigate's plight now known, HMS *Consort* steamed down from Nanking to assist, but she, too, came under fire from shore batteries before destroying several of them with her 4.5-inch guns.

The plan was to take *Amethyst* in tow but Communist fire began taking a toll on the rescuer as well, and *Consort*



COL Dewar-Durie, Attaché from the British Embassy at Nanking, took these photos of injured crewmembers at Chingkiang prior to their departure by train for Shanghai. Courtesy of Ewart Chivers

was forced to proceed downriver after taking 39 casualties of her own—9 dead and 30 wounded.

For the next 15 hours, the ship's depleted crew worked to back the frigate off the mud bank. After lightening the vessel by throwing equipment overboard, they were finally successful. The ship then quietly ghosted upriver and anchored off T'ai P'ing Island to await assistance from HMS *Black Swan* and HMS *London*. When those two vessels arrived, they came under heavy fire, took casualties, and were forced to retire. *London* had 12 killed and 20 wounded. Seven were wounded aboard *Black Swan*. Late in the afternoon of 21 April, a Sunderland flying boat carrying a Royal Air Force physician and medical supplies landed in the river, but it, too, drew Communist fire and had to retreat.

With the aid of Nationalist Chinese forces, the most seriously wounded were finally evacuated to shore, where Chinese medical personnel treated them. Nevertheless, many of the British sailors, now hours into their ordeal, some in shock and others having lost significant amounts of blood, required additional care. And time was running out.



U.S. Navy physician LCDR James Packard, Jr., had not planned to get involved in the Chinese civil war. The World War II veteran was assigned to the U.S. Embassy in Nanking as Assistant Naval Attaché. As part of his duties he provided medical care not only for American personnel involved in embassy business but also for dependents and occasionally personnel of other nearby diplomatic missions and embassies. "It was a small community and everybody

was close together. I took care of so many of them, especially the English."

Although not on the embassy grounds, Dr. Packard's clinic consisted of only a few rooms, and it was not equipped to handle anything requiring surgery. "In those days I took care of anyone who walked in," Packard recalls. "I didn't do surgery of any kind and told patients I was not going to deliver any babies. In fact, I delivered only two babies while I was in China."

Nevertheless, the Navy physician practiced medicine intensively, at least as far as volume was concerned. "I was busy from the first thing in the morning until about 5 o'clock at night."

Dr. Packard's routine was about to get even busier. Rumor had it that a close ally was under attack by the Communists, resulting in many dead and wounded.

On Thursday morning, 21 April, Dr. Packard and his hospital corpsman, HMC C.A. di Giacinto, left Nanking in an embassy jeep for Chinkiang, a town near Rose Island. They carried a precious cargo of sorely needed medical provisions. "We took a lot of supplies—IV fluids, and of course, bandages, and antibiotics."

Slowed down by terrible roads, they didn't reach their objective until 3:30 p.m. In the meantime the Nationalists had procured two trucks to evacuate the wounded to the coast once they had been removed from *Amethyst*.

Another vehicle bearing two British officers joined what was now a four-vehicle convoy, which left Chinkiang and continued on increasingly deplorable roads to where the ship awaited them near T'ai P'ing Island. About 23 miles east of Chinkiang, the relief party reached a small farming

village where the road played out and the motor vehicles were abandoned. With the medical supplies transferred to two large wheelbarrows, the relief party, now augmented by several Chinese laborers, pushed on through rice paddies and across fields.

About the same time the Americans arrived in Chinkiang, a Chinese army doctor and several orderlies were providing the first medical assistance to the casualties since the initial attack the day before.

When they finally arrived at Rose Island, Dr. Packard and Chief di Giacinto found wounded British sailors “scattered all over and shot to hell,” with burns and the kinds of injuries inflicted by shell splinters and secondary missiles resulting from exploding ordnance. The two men treated symptoms of shock, gave morphine, stanching the bleeding with bandages, and administered blood plasma and other IV fluids and antibiotics. It was immediately apparent to the Navy doctor that these men needed to be evacuated to more advanced medical care as soon as possible. That meant moving them to the closest railroad line connecting Chinkiang with Shanghai.

Several trucks had been commandeered and their floorboards lined with hay to accommodate the most seriously wounded, but due to the terrible roads, this effort offered only minimal relief for patients who stoically bore their agony. Chinese volunteers carried the remaining injured in litters. The walking wounded shuffled along under their own power. As Dr. Packard recalls, “We dropped two or three off at a missionary station on our march to the railroad station because they just couldn’t stand any more of the marching and live.”

When the party finally reached the railroad station about 8:00 a.m. on 22 April after a 3-hour ordeal, large milling crowds only hampered the proceedings. Chinese volunteers and uninjured *Amethyst* sailors carefully transferred the wounded from the trucks and brought them to the end of the railway station platform where Dr. Packard and nurses provided food and additional medical care. (Chief di Giacinto had departed earlier for Nanking.) With those tasks accomplished, the stretchers were then loaded aboard the eastbound train for Shanghai. Dr. Packard accompanied them on the journey and continued to administer IV fluids and other medical treatment until the wounded reached their destination.

More evidence of the enduring Anglo-American friendship awaited the *Amethyst* survivors. Having learned of what was now being called the “Yangtze Incident” or the “Amethyst Crisis,” the U.S. government offered all U.S. Navy medical assets in Shanghai to the British authorities, including the hospital ship USS *Repose* (AH-16). Consequently, *Repose* received casualties from *Amethyst*, *London*, and *Black Swan*. On 29 April 1949, the hospital ship

steamed to Hong Kong with 77 British casualties and 118 American evacuees from Shanghai.

With his services no longer required, LCDR Packard flew back to Nanking to resume his duties at the U.S. Embassy.



Negotiations between the British government and the Communists to free *Amethyst* from her Yangtze captivity dragged on for 3 months without success. Finally, on the night of 30 July 1949, the badly damaged frigate’s skeleton crew slipped her anchor cable and made a 160-mile run for the mouth of the Yangtze, dodging enemy fire from both riverbanks. Her success in rejoining the fleet south of Woosong became known after the triumphant frigate flashed the following message: “Have rejoined the fleet . . . No damage or casualties. God Save the King.”

Following LCDR James Packard’s return to the U.S. Embassy in Nanking, pressure on the Nationalist capital from the People’s Liberation Army grew more intense. In July 1949, the city fell to Mao’s forces. As life became more restricted under Communist rule, American personnel were evacuated, the U.S. Embassy closed, and relations between the two nations were suspended. It was not until 1979 that diplomatic relations were finally established between the United States and the People’s Republic of China.

Following his China tour, James Packard had several other assignments before resigning from the Navy following 8 years of service. He subsequently went into private practice, worked on the Rosebud Indian reservation in South Dakota, and retired, having served as a physician for more than 50 years.



Shortly after the *Amethyst* incident, positive British reaction to Dr. Packard’s deeds were directed to the Secretary of State and the doctor’s superiors at the Navy’s Bureau of Medicine and Surgery. A letter from British Ambassador to China Sir Ralph Stevenson to Secretary of State Dean Acheson is indicative. “It gives me particular pleasure to express our indebtedness to two members of your Embassy establishment, Lt. Commander J.W. Packard and Hospitalman Chief C.A. di Giacinto whose professional skill was invaluable at this critical moment. Their selfless devotion to the care of the wounded at great personal inconvenience and at considerable risk were worthy of the highest traditions of the service to which they belong. . . .”

These letters notwithstanding, many in the British diplomatic community and in the Royal Navy felt Dr.

*Letter of Ralph S. Stevenson to Secretary of State, 10 May 1949.

Packard deserved far more recognition. Could not the British Government—King George VI himself—confer a medal? Indeed, during World War II, decorations for valor flowed freely among the two close allies after Congress passed special legislation allowing for American citizens, under certain conditions, to accept foreign awards.

Unfortunately, since 1945, this legislation had been allowed to lapse. Dr. Packard's admirers discovered that in peacetime an American citizen could only accept a foreign decoration after enactment of special legislation. Ambassador Stevenson pointed out the dilemma. When he inquired as to how an award could be granted, U.S. officials informed him "that the provisions of the United States Constitution prevent persons in the employment of the State from receiving foreign decorations without the assent of Congress. The special act of Congress enabling members of the United States forces to accept decorations from the Allies for war services expired some time ago. I therefore had to content myself with writing Packard a warm letter of appreciation which was published in the *United States*. . . . I feel there is nothing more to be done in the matter"**.

CAPT Kenney, in the Office of the High Commissioner for Canada, responded tongue-in-cheek: "It looks as if the only solution is another war and as much as I like Dr. Pack [sic] and would like to see him get well deserved recognition through some decoration, I hardly want to see him get it if it means a world war to bring it to him."** As World War III never transpired, the impasse was never resolved.

Fifty-eight years after Chinese Communist gunners plunged their frigate into the limelight, several *Amethyst* veterans, now in their 80s and 90s, made special efforts to find their American benefactor and convey their own belated thanks. This past March, those efforts were



Dr. Packard today. Photo by Katherine Osman

rewarded when they located Dr. Packard, now 93, living in Gainesville, FL. Letters, emails, and trans-Atlantic calls have now reunited the sailors and the man who patched their wounds and saved their lives more than a half century ago. Even though the Yangtze Incident has become a mere footnote in history, the ensuing years have in no way diminished the affection these old sailors have for their American angel of mercy. If they could have their way, Queen Elizabeth would correct a historic

oversight by decorating the aging U.S. Navy physician in Buckingham Palace.

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Special thanks to Cheryl Freeman whose tireless efforts reunited the *Amethyst* veterans with their U.S. Navy physician.

*Letter of T.C. Davis to CAPT William Kenney, 5 May 1950.

**Letter of William Kenney to T.C. Davis, 31 May 1950.



“We Have Lost 134 of Our Brothers”

When the air war against North Vietnam commenced following the Tonkin Gulf incident in the summer of 1964, U.S. carriers began operating in an area of the South China Sea soon to be called “Yankee Station.” Some of the most frenetic and dangerous places to work were on the decks of such warships as Constellation (CVA-64), Franklin D. Roosevelt (CVA-42), Bon Homme Richard (CVA-31), Oriskany (VA-34), and Forrestal (CVA-59). Young men in the prime of their lives fueled and armed aircraft, then jockeyed them into position for launch from one of the vessel’s catapults. And when the missions were over, the planes and crewmen—who had survived North Vietnamese anti-aircraft missiles and gunfire—returned to the mother ship, trapped by arresting cables stretched across the deck and brought to a sudden stop.

This routine ground on day after day and year after year, the activity waxing and waning with the war’s tempo. The general calmness of the seas in the near tropical environment belied the fact that sudden tragedy could strike at any moment. On 25 July 1967 an errant missile hit a fully fueled and armed A-4D Skyhawk parked on the flight deck and piloted by LT John McCain.

AO3 Paul Friedman was an airman specializing in aviation ordnance when he reported aboard Forrestal. It was his first assignment. “I was just awed by how big it was. It was a proud ship with a proud crew.”

I was sleeping on the second deck, the deck right below the hangar bay. That’s where most of the ship’s activity was and where the mess decks were. At that time, my berthing compartment was back by the fantail in the middle of the ship.

I didn’t hear the bombs going off. I didn’t hear “General Quarters!” I didn’t hear the first alarm, which was “Fire! Fire!” Fires happen on the carrier all the time. That’s the way it was. And they were usually small fires that were quickly put out. But now we heard “Fire! Fire!” Immediately after that the GQ went off. Seconds later the first bomb exploded, but I didn’t hear that and a lot of guys didn’t hear it either. I was awakened by the second or third bomb blast and noticed that I had a wound. I think one of the bomb fragments came all the way down to where I was sleeping. The bulkhead next to me was cracked and I saw flames. If I had been sleeping at the other end of the bed, the shrapnel would have hit me in the head. So, in a way, it was the million-dollar wound.

One of the guys was standing next to my rack checking to see if I was all right. I noticed a red hole in the sole of my foot, right by the instep. I couldn’t walk on it so I had to hop. We both decided it was time to get the hell out of there. I hobbled to the port passageway where everybody else was headed. We were all trying to make our way forward—away from where the bombs were going off. I made it over to the port side and then another big explosion rocked the ship and went right down the stairway. I saw them carrying a shipmate with a head wound. By now everyone was in the passageway heading forward. And all this time I was hopping, trying to make my way forward. I must have been slowing everybody down because one of the guys grabbed me under my arm like a twig and supported me. I still had one foot on the ground but somehow he got me to sick bay.

I saw people burned and others lying around waiting for treatment. I thought I shouldn’t be in sick bay because what I witnessed I never want to see again—people with



Exhausted crewmembers continue to fight the fire amidst exploding ordnance and the remains of wrecked aircraft.

burns all over their bodies. A guy sitting next to me named Howard had a compound fracture.

All I wanted was a battle dressing and a tetanus shot. That's how much I thought about my wound. I wasn't really in any pain and it wasn't bleeding. I just wanted to cover it up. I was worried about what my mom always used to tell me. "Be careful. You'll get blood poisoning."

The chief corpsman came over and asked if I wanted morphine. I said, "No, give it to Howard." He was the one with the compound fracture.

They also brought in a chief or a warrant officer who didn't look like he had a scratch on him. Nevertheless, the corpsman told the guys who brought him in, "We can't do anything for him." He was already dead.

For my wound, they gave me one of those big battle dressings. Then time went by as I listened to the bombs going off, praying that they'd be able to stop them. They were exploding for the first 5 or 10 minutes. I heard nine detonations.

Eventually, I was taken through the smoky sick bay up an elevator to one of the choppers. I later wrote a letter to my mom about the fire.

Friedman's letter to his mother reads as follows:

"We were taken to the carrier *Oriskany*, which was half a mile away. When we landed, I was the first one off. They put me on a stretcher and carried me across the flight deck. Crewmembers and press were taking pictures but later they were ordered to stop photographing the wounded.

"I was placed on a bomb elevator which took me and my shipmates down to sick bay. They

placed me in a rack next to a shipmate who had burns to his arms and his face. He was on the flight deck when the accident occurred and had jumped off the flight deck to escape the fire and burns he was experiencing. I remember him saying that during that eighty-foot descent into the ocean, he had seen his whole life go by and hoped he wouldn't hit any debris in the water below. Luckily, he was picked up by one of our destroyer escorts. Either the *Rupertus*, the *Tucker*, or the *MacKenzie* came alongside to fight the fire and pull survivors out of the water.

"When I arrived around 3 p.m. the doctors had many bad burn cases to treat, so they didn't get around to me until 5 p.m. When they did, the doctors decided not to stitch my wound but leave

it with an open dressing. They cut off some skin around the wound. The doctor gave me a shot of Demerol before treating me.

"Around 8 p.m. we found out that we would be flown off again, this time to the hospital ship *Repose*. So at 3 a.m. July 30th, I was helicoptered off to the *Repose*, where they x-rayed me and said I had shrapnel in my wound and that they would take care of me. I didn't know when I'd be getting off the ship. The *Forrestal* is in bad shape and might be heading for Subic Bay [Philippines] or the States. The damage and loss of life is catastrophic. We have lost 134 of our brothers." ✍

Friedman and many of his injured shipmates received additional treatment aboard USS Repose (AH-16). His wound was cleaned further and penicillin administered twice a day to ward off infection. He was then evacuated back to the States for further convalescence at Naval Hospital St. Albans New York, which was located near his home.

After recovering from his wound, Friedman was discharged from the Navy for a previous injury. He is currently active in the USS Forrestal Association and resides in Coral Springs, FL.



Dwarfed by the burning *Forrestal*, USS *Rupertus* (DD-851) stands by to assist.

US Navy photos

In Memoriam

CAPT Donald C. Kent, MC, USN (Ret.) died on 21 April 2007 in Stonington, CT. He was 83. Born in Bonesteel, SD, on 26 April 1923, he joined the Army Special Training Unit at Yale University as an enlisted soldier during World War II. After the Army sent him to an Army Special Training Program (ASTP) unit at Yale for a semester, he was accepted into medical school. But until there was room for him, he worked as an x-ray technician at the Fitzsimons Army General Hospital in Denver, CO. By the time he finished an accelerated course at the University of Nebraska Medical School, the war was over and he was discharged from the Army.

After just a year in private practice, Dr. Kent applied for a reserve commission in the Navy. In 1951, he went to the Naval Medical School in Bethesda, MD, where he studied tropical diseases and public health. He then took an intensified course in aerospace medicine in Pensacola, FL, and a 5-week submarine medicine course in New London, CT. After more training at the Field Medical Service School, Camp Lejeune, NC, it looked as though he was now prepared for an operational assignment in any branch of Navy medicine. At the time, he recalls, they were really having a hard time getting people to volunteer for Korea. Without much further thought, he made his choice—the 1st Marine Division.

LTJG Kent soon found himself up near the 38th Parallel on the staff of Able Medical Company during some of the heaviest fighting of the Korean War. “A man could be hit, given first aid within minutes, be on a helicopter in half an hour, and on an operating table within an hour,” he recalled in a 2000 interview with *Navy Medicine*. “It was a fast evacuation and fast care. Even though I had only had a rotating internship and wasn’t really a surgeon, I was acting surgeon. In fact, I was the battalion surgeon. That was my title. I wished I had more surgical training, but it wasn’t available at that stage. There were instances when I did what a corpsman probably would not have been able to do. But the average things we did such as stopping bleeding—clamping off bleeding vessels—he could have done.”

Following the war, Dr. Kent made the Navy a career, serving in a variety of posts, including the Mediterranean during the Suez crisis in 1956. He was chief of medical services at several naval hospitals during the Vietnam War, retiring from the Navy in 1971 after 25 years service.



CAPT Kent held the Legion of Merit, Bronze Star, Purple Heart, and was a recipient of several other meritorious awards for distinguished services.

Following his Navy career, Dr. Kent served as medical director of the American Lung Association and Life Extension Institute in New York, NY, and concurrently taught clinical medicine at NYU Bellevue and downstate Medical School from 1971 to 1982. He then was medical director of Electric Boat in Groton, CT, from 1982 until his retirement from that post in 1988. He continued working at Electric Boat as consulting staff physician and at Pequot Health Center in Groton and Health Services at Pfizer Central Research.

Dr. Kent was active in medical research and medical writing with 225 published articles. His specialties were pulmonary disease, infectious disease, and occupational health and safety programs. He was a Fellow of the American College of Physicians, the American College of Chest Physicians, and the American Occupational Medicine Association.✍

Book Review

***Frozen in Memory: U.S. Navy Medicine in the Korean War* by Jan K. Herman. Printed by Booklocker.com, Inc. 2006, 224 pages.**

In the preface of his latest book *Frozen in Memory: U.S. Navy Medicine in the Korean War*, BUMED Historian Jan K. Herman refers to the fact that for many Americans the movie and television series *M*A*S*H* are synonymous with the Korean War and then ponders “But was it really like that?” Having always thought that I was possibly the only person on the planet who felt that the television series was obnoxious, unfunny, and disrespectful, it was not a surprise at all that all the interviewed veteran doctors, nurses, and corpsmen who served in Korea also disliked the series. As one Navy surgeon related, “There was nothing funny about Korea.”

In this sequel to *Battle Station Sick Bay: Navy Medicine in World War II*, Herman uses the same extremely effective style—allowing the men and women to tell their stories in the first person. Having interviewed almost all the veterans in the book personally, as well as drawing on some historical archives, Herman weaves a compelling, highly readable, and at times gut-wrenching book that is also very timely considering Navy medicine’s current role in the Middle East. There is one major difference compared to his previous work. In addition to doctors, nurses, flight nurses, and corpsmen telling their stories, in *Frozen in Memory*, Herman also has the recipients of the combat medical care, mainly wounded United States Marines, also tell their stories. It makes for powerful reading.

The invasion of South Korea in June of 1950 found the United States unprepared for a major conflict so quickly after the end of World War II. The military had rapidly downsized, was medically understaffed, and was ill-prepared for another overseas conflict. The Navy Medical Department rose to the occasion, but there was a price to pay. Many of the doctors were right out of internship and were, in essence, general medical officers being sent in for a surgical support mission. Virtually none of them, with the exception of the legendary CAPT Eugene Hering, had served in World War II or had combat casualty experience. Yet they got the job done under the most adverse of circumstances. The heroism of Navy corpsmen has never been greater than in Korea. Minimally trained doctors and frontline corpsmen became saviors of combat casualties who would have died in previous wars. It was also the first conflict that saw the widespread use of antibiotics and the true genesis of helicopter casualty evacuation.

Frozen in Memory describes what our medical forces coped with at Pusan and Inchon as well as the horrific Chosin Reservoir campaign and the subsequent stalemated war around the Main Line of Resistance (MLR). The role of the hospital ships *Consolation*, *Haven*, and *Repose* is

described by the medical personnel who worked tirelessly aboard these ships to save their patient’s lives. We read the words of the late VADM Joel T. Boone as he describes his visit to the hospital ship *Consolation* via helicopter and being lowered to the ship by a metal cable. It was this experience that gave Boone the idea for adding helicopter landing pads on the hospital ships.

Two of the narratives of the medical personnel are horrific on a personal level. Navy nurse ENS Dorothy Venerloh was aboard the hospital ship *USS Benevolence* when it collided with the freighter *SS Mary Luckenbach* and she and other survivors spent over 2 hours in the frigid Pacific Ocean off the coast of San Francisco before being rescued. HM3 Billy R. Penn describes being overrun by Chinese forces near the 38th Parallel. After fierce hand-to-hand combat, Penn was taken prisoner after being wounded several times and then being buried alive by an explosion in a bunker. Blinded by the explosion, he suffered torture for nearly 2 months before being repatriated in a prison exchange. All the narratives of the wounded Marines, describing the heroism of Navy corpsmen who rescued them and the tireless efforts of doctors and nurses who cared for them, tell the story of a Navy Medical Department that performed its mission in an exemplary manner. In a fascinating act of closure, Herman describes how he actually reunited several wounded Marines with the corpsmen, doctors, and nurses who saved their lives. These medical personnel, able to recall the Marines, had no idea that their patients actually survived. Reunions between the corpsmen and doctors and the patients they assumed had died occurred nearly 50 years after the war.

Korea is often referred to as the “Forgotten War,” but the service and sacrifices made by U.S. Navy medical personnel should never be forgotten. Herman has written a great historical work to commemorate the valor of these young corpsmen, doctors, and nurses. At the end of *Frozen in Memory* Herman relates that several of the veterans he interviewed had returned to South Korea in recent years. He asked these men and women “Was all the blood and sacrifice worth it?” Noting the impressive modernization, the high standard of living, and the individual freedoms of the South Koreans, they all concurred that it was. This is best summed up in the words of Dr. Henry Litvin who served with the U.S. Marines at Inchon and Chosin Reservoir, who said “There are few things in my life that I can feel as proud of as my service to this country in Korea with the 2nd battalion, 5th Marines. I didn’t like it one damn bit. I was there and luckily I survived. The Navy needed doctors and I happened to be one of them. I’ve been prouder of that than anything else I’ve ever done.”✍

CAPT Lee R. Mandel, MC, USN, is Force Medical Officer, U.S. Atlantic Fleet, Norfolk, VA.

Navy Medicine ca. 1943



Photo courtesy of Kevin Bash

In the recreation room, Marines James Tallant, John Virgopio, and Russell Twedt play pool with Gary Cooper. Cooper was a regular at Naval Hospital Corona, CA. He once introduced himself to a patient with "Hi, I'm Gary Cooper." The patient then asked, "Sorry Gary, I know we know each other, just can't place you; was it Guadalcanal or Pearl Harbor?"

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